Alabama Medicaid Administrative Code

April 2011

Chapter 1 - General

Rule No. 560-X-1-.01. Organizational Description.

The Alabama Medicaid Agency (hereinafter called "Medicaid") administers the State Plan for Medical Assistance under Title XIX of the Social Security Act (hereinafter called "State Plan") which provides payment for authorized medical services and supplies available to categorically eligible recipients. Certain services are mandatory under Section 1902, Title XIX of the Social Security Act and other services provided are available at the option of the State of Alabama.

(1) The mandatory services include:
- (a) Physician Services
- (b) Inpatient and Outpatient Hospital Services
- (c) Rural Health Clinic Services
- (d) Laboratory and X-ray Services
- (e) Skilled Nursing Facilities Services
- (f) Early and Periodic Screening Diagnosis and Treatment (includes Dental)
- (g) Home Health Care Services and Durable Medical Equipment
- (h) Family Planning
- (i) Nurse-Midwives Services
- (j) SSA Title IV-E, Foster Care Medical Services

(2) The optional services include:
- (a) Intermediate Care Facilities Services
- (b) Prescribed Drugs
- (c) Optometric Services
- (d) Ambulance Services
- (e) Hearing Aids
- (f) Intermediate Care Facilities for Mentally Retarded and Mental Disease Services
- (g) Prosthetic Devices
- (h) Outpatient Surgical Services

(3) The following chapters contain information about the administration of the Medicaid program and the extent of the covered services available for eligible categorically needy recipients when medically prescribed.

Authority: Social Security Act, Title XIX, Section 1902(a)(10)(A); 42 C.F.R. Section 440.210; and Executive Order Numbers 38, 81 and 83. Rule effective October 1, 1982.

Rule No. 560-X-1-.02. Laws and Publications Applicable to Medicaid.

The legal authorities under which the Medicaid Program is operated are:

(1) Title XIX of the Social Security Act as amended.

(2) 42 C.F.R. Section 430, et seq.

(3) 45 C.F.R. Section 205, et seq.

(4) Alabama Executive Order No. 8, dated June 30, 1967, Executive Order No. 32, dated February 17, 1972, Executive Order No. 81, dated June 16, 1977, Executive Order No. 83, dated September 26, 1977, and Executive Order No. 38, dated March 2, 1981.

(5) Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as approved by the Federal Department of Health and Human Services.

(6) Section 1634, Public Law 92-603.

(7) Code of Alabama, 1975 Sec. 22-6-1, 27-14-11,1, 35-1-2, 36-13-8, and 36-13-9, et seq.

(8) Title VI of the Civil Rights Act of 1964, as amended.

(9) Section 504 of the Rehabilitation Act of 1973, as amended.

(10) The Age Discrimination Act of 1975.

(11) Alabama Medicaid Agency Administrative Code.

(12) Provider Notices.

(13) Clinical Laboratory Improvement Amendments of 1988 (CLIA), P.L. 100-578 (42 U.S.C. Section 263a).

Authority: All regulations cited above. Amended June 27, 1983; Amended January 13, 1993, based on OBRA '90, Section 1927. Effective date of this amendment May 13, 1993.

Rule No. 560-X-1-.03. Administration of the Alabama Medicaid Program.

The Alabama Medicaid Agency administers the state Medicaid Program as directed by the Governor. The head of the agency is the Commissioner, who serves at the pleasure of the Governor.

Authority: 42 C.F.R. Section 431.10; Executive Order No. 81, dated June 16, 1977, and Executive Order No. 83, dated September 26, 1977.

Rule No. 560-X-1-.04. Agencies Responsible for Medicaid Eligibility. (See Chapter 25 for detailed eligibility criteria.)

Applicants eligible for Medicaid services are certified to the Alabama Medicaid Agency by the following agencies:

(1) The Social Security Administration certifies aged, blind, and disabled applicants for the Federal Supplemental Security Income (SSI) Program. In Alabama, individuals eligible for SSI are eligible for Medicaid under Title XVI, Section 1902(b) of the Social Security Act and Section 1634, Public Law, 92-603.

(2) The Alabama Department of Human Resources (DHR) certifies eligibility at county DHR offices for some groups not eligible for SSI. These groups are discussed in Chapter 25.

(3) The Alabama Medicaid Agency certifies Medicaid eligibility for individuals listed in Chapter 25 through its certification district offices located throughout Alabama. Generally, there is no Medicaid coverage for individuals who are confined to a public institution unless it is a medical institution. See Chapter 25 for eligibility criteria and the descriptions of the groups covered.

(4) The Alabama Medicaid Agency restricts, and terminates eligibility in cases of fraud, abuse, and misuse.

Authority: Executive Order No. 83, dated September 26, 1977. Social Security Act 1902(a)(10)(A)(ii)(V) as amended by Section 9510 of COBRA 1985, 42 C.F.R. Section 431.10; Public Law 100-203, Sections 9108, 9116, and 9119; 42 C.F.R. Section 435.231; Public Law 100-360, Section 301. Rule effective October 1, 1982. Amended August 10, 1987. Emergency Rule effective January 8, 1988. Amended April 12, 1988 and July 12, 1988. Emergency Rule effective July 1, 1988. Amended September 9, 1988. This Emergency Rule effective January 1, 1989. Amended April 14, 1989. Effective date of this amendment January 13, 1993.

Rule No. 560-X-1-.05. Licensure and Certification of Certain Providers.

The Bureau of Licensure and Certification, Alabama Department of Public Health is responsible, through agreement with Medicaid, for licensing hospitals, skilled and intermediate care nursing facilities, and certain other health related facilities for participation in the Medicaid program.

Authority: 42 C.F.R. Section 431.610 and 431.620; Social Security Act, Title XIX, Section 1902(a)(33); Agreement, September 14, 1980, Bureau of Licensure and Certification, Department of Public Health. Rule effective October 1, 1982.

Rule No. 560-X-1-.06. Fiscal Agent.

(1) The Alabama Medicaid Agency contracts with a fiscal agent to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Alabama Title XIX State Plan. The present fiscal agent contract is with EDS , Post Office Box 7600, Montgomery, Alabama. Their toll free telephone number is 1-800-688-7989.

(2) The fiscal agent will provide current detailed claims processing procedures in a manual format for all claim types covered by Medicaid services. The fiscal agent will prepare and distribute the Alabama Medicaid Agency Provider Manual to providers of Medicaid services. Such manual is for guidance of providers in filing and preparing claims.

(3) Providers with questions about claims should contact the fiscal agent. Only unsolved problems or provider dissatisfaction with the response of the fiscal agent should be directed to Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104, telephone number, 242-5010.

Authority: Title XIX, Social Security Act, Section 1902(a)(4); 42 C.F.R., Section 431.510. Rule effective October 1, 1982.

Rule No. 560-X-1-.07. Provider Rights and Responsibilities.

(1) In accordance with federal law, Medicaid providers shall ensure that no person will, on the grounds of race, color, creed, national origin, age or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by the Agency.

(2) Compliance with Federal Civil Rights and Rehabilitation Acts is required of a provider's participating in the Alabama Medicaid Program.

(3) Providers have freedom of choice to accept or deny Medicaid payment for medically necessary services rendered during a particular visit. This is true for new or established patients. However, the provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted, and the patient will be responsible for the bill. The fact that Medicaid payment will not be accepted would be recorded in the patient's medical record, if one exists.

(4) Providers who agree to accept Medicaid payment must agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, e.g. epidurals, spinal anesthetic, these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. These services are covered by, and billable to Medicaid. Providers may not bill Medicaid recipients they have accepted as patients for covered labor and delivery related pain management services.

(5) Providers, including those under contract, must be aware of participation requirements that may be imposed due to managed care systems operating in the medical community. In those areas operating under a managed care system, services offered by providers may be limited to certain eligibility groups or certain geographic locations.

Authority: Civil Rights Act of 1964, Titles VI and VII; Rehabilitation Act of 1973; Age Discrimination Act of 1975, and State Plan, Attachment 7.2-A. Rule effective October 1, 1982. Rule Amended December 19, 1992. Effective date of this amendment March 14, 1997.

Rule No. 560-X-1-.08. Recipient Rights and Responsibilities.

(1) Free choice of selecting providers of health care is a legal right of every recipient of Medicaid care and services. Freedom of choice related to an individual's opportunity to make his own decisions for his own reasons, free from the arbitrary authority of others is a recipient's right.

(2) Where prior authorization is required for Medicaid services, a recipient's choice among qualified providers shall not be restricted except by special action of the Alabama Medicaid Agency to restrict or "lock-in" a recipient to a provider of choice. (See Chapters four and five for additional information on recipient restrictions.)

(3) A recipient who believes that his free choice of provider has been denied or impaired has the right to request a fair hearing before the Alabama Medicaid Agency.

(4) When a recipient fails to advise a provider of his Medicaid eligibility and furnish other information necessary to file the claim within the time allowed by Medicaid, the provider is under no obligation to file and may elect to file with Medicaid or to bill the patient.

Authority: Social Security Act, Title XIX; 42 C.F.R. Section 431.51 & 431.54. Rule effective October 1, 1982. Effective date of this amendment August 10, 1987.

Rule No. 560-X-1-.09. Recipient Identification Number.

(1) The identification number of Medicaid eligible recipients contains thirteen (13) digits. The first three will be "000" followed by the recipient's nine (9) digit Social Security number and a number verification check digit.

(2) The Medicaid identification number will be embossed on a plastic Medicaid eligibility card issued to each individual entitled to Medicaid.

(a) Providers should question patients aged 65 or older about entitlement to Medicare.

(b) Where a Medicare claim number has not been assigned for those aged 65 or older, the recipient should be referred to the local SSA office to make application for Medicare.

(c) Claims for services covered by Medicare for persons sixty-five (65) or older may not be submitted until a Medicare number has been assigned; then claim should be filed first with Medicare with the Medicaid number listed on the Medicare claim as "other insurance".

(d) A Medicare claim number with a suffix "M" indicates there is no Medicare Part A (hospital insurance) entitlement. Hospital claims for this type number may be filed with Medicaid as regular Medicaid claims.

Authority: State Plan for Medical Assistance. Rule effective October 1, 1982. Amended May 1, 1983; June 8, 1983 and November 10, 1987. Effective date of this amendment January 13 , 1993.

Rule No. 560-X-1-.10. Provider Identification Number.

(1) All providers, except pharmacies, participating in the Alabama Medicaid Program are assigned a nine digit identification number by the Alabama Medicaid Agency fiscal agent. Pharmacies (drug providers) are assigned a provider identification number by the Medicaid Pharmaceutical Program.

(2) Providers must be licensed to practice in the state in which the service is rendered.

Authority: State Plan for Medical Assistance and the Alabama Medicaid Agency Administrative Code. Rule effective October 1, 1982. Amended May 1, 1983.

Rule No. 560-X-1-.11. Medicaid Eligibility Card.

Individuals certified eligible for Medicaid will receive a plastic Medicaid Eligibility Card through the mail with the following exceptions: certain unborns; recipients certified with a pseudo number; and recipients certified for a closed period of retroactive eligibility. These individuals will receive a one time issuance of a paper Medicaid card. Also, Medicaid recipients residing in a long term care facility will not receive a plastic Medicaid card. Each month the long term care provider will receive a computer printout listing of all Medicaid eligible recipients in the respective facility.

(1) The recipient is required to present his plastic Medicaid card and proper identification to a provider of medical care or services. The provider must verify eligibility through AVRS, MACSAS, or the Provider Inquiry Unit.

(2) Medicaid claims may be submitted for unpaid charges incurred during three (3) months prior to the month of application for an SSI recipient. Eligibility for those services must be established before claims submission.

(3) When a recipient loses or fails to receive a plastic eligibility card he/she should write or call the Alabama Medicaid Agency.

(a) Should the recipient require Medicaid services before receiving a replacement card he/she is responsible for furnishing his Medicaid number to the provider at a later time.

(b) Providers of Medicaid services shall obtain the Medicaid eligibility number directly from the recipient to verify eligibility or submit claims for services furnished the recipient. Where the Medicaid number is not available from the recipient it may be obtained from the Medicaid Agency by sending a completed inquiry form. Providers must state in their request that they have provided authorized services, supplies, or equipment to the individual whose Medicaid number is being verified.

(c) Claims submitted for services furnished a recipient must contain all thirteen digits of the recipient's Medicaid number.

(4) Providers of Medicaid services shall not submit lists of names, addresses and/or Medicaid numbers of individuals to the Alabama Medicaid Agency for verification of eligibility.

Authority: State Plan; Social Security Act, Title XIX, 42 C.F.R. Section 430, et.seq. Provider Notice 82-28, September 27, 1982. Rule effective October 1, 1982. Amended May 1, 1983; July 9, 1985; August 10, 1987, and November 10, 1987. Emergency rule effective November 16, 1987. Amended March 12, 1988. Effective date of this amendment January 13, 1993.

Rule No. 560-X-1-.12. Medicaid Eligibility Termination.

(1) When a recipient is notified by the Social Security Administration that he is no longer eligible for Supplemental Security Income, Medicaid will send him a termination notice unless he remains eligible for Medicaid under Alabama criteria. A recipient shall be notified at least 10 days before the effective date of termination from Medicaid benefits. Chapter 28 shows two types of termination notices.

(2) In all other terminations Medicaid and the Department of Human Resources issue Termination of Award Notices ending Medicaid eligibility and public assistance payments.

(3) Medicaid recipients residing in an institution may lose eligibility if they are discharged from the institution to home, or if their monthly income rises above the ceiling for Medicaid eligibility.

(4) If a Medicaid eligible person, other than a foster child, moves permanently outside the State of Alabama, he will be deleted from the Alabama Medicaid eligibility file.

(5) Foster children will lose eligibility when they cease to be foster children.

(6) Minors eligible for Early and Periodic Screening, Diagnosis and Treatment (hereinafter called EPSDT) will lose eligibility under this program at age 18.

(7) Medicaid recipients will lose eligibility when income exceeds the ceiling level established for eligibility.

Authority: State Plan, 42 C.F.R. Section 430, et seq.; Social Security Act, Title XIX. Rule effective October 1, 1982. Amended June 8, 1985. Effective date of amendment January 13, 1993.

Rule No. 560-X-1-.13. Medicaid Payments and Recoupments for Health Services, Supplies, and Equipment.

(1) Direct payments are made for allowable charges to providers for covered medical services and supplies furnished eligible Medicaid recipients.

(a) Providers who wish to participate in the Alabama Medicaid Program must be enrolled, receive a provider number, and in most cases sign a contract with Medicaid.

(b) Licensed physicians, dentists, and osteopaths are exempt from a contract requirement, at the present time, but they do need to enroll with the fiscal agent and be assigned a provider number. Each claim filed constitutes a contract with Medicaid, embodying by reference all applicable provisions of the State Plan, this Code, and federal and state regulations.

(2) Crossover payments are partial payments to providers by Medicaid for covered Medicaid services, supplies and equipment furnished to recipients eligible for both Medicare and Medicaid.

(a) Providers of services, supplies, and equipment to eligible Medicare/Medicaid recipients must, if they accept Medicare assignment, first send their claims to Medicare and not to the Medicaid fiscal agent.

(b) If the Alabama Medicare carrier is Blue Cross and Blue Shield of Alabama, and if they accept a provider's claim they will pay him the allowable charges and forward the information to the Medicaid Fiscal agent for payment to the provider of the deductible and co-insurance charges. This is the "crossover" payment.

(3) By entering into a contract with Medicaid, the provider acknowledges that payments thereunder are subject to review, audit, adjustment and recoupment actions. In the event of any transfer, sale, assignment, merger or replacement between and among providers, Medicaid may look both to the original provider and any successor, transferee or replacement provider for recovery of any funds improperly paid. Providers should take this right of Medicaid into account and make appropriate provision therefore in their business transactions.

(4) All sites providing laboratory testing services to Medicaid recipients, either directly by provider, or through contract, must be Clinical Laboratory Improvement Amendments (CLIA) certified to provide the level of testing complexity required. Providers are responsible to assure Medicaid that all CLIA regulations are strictly adhered to, both now and as regulations change in the future. Providers are responsible for providing Medicaid waiver or certification numbers as applicable.

(5) Laboratories which do not meet CLIA certification standards are not eligible for reimbursement for laboratory services from the Alabama Medicaid Program.

Authority: Social Security Act, Title XIX, Section 1902(a)(32); 42 C.F.R. 447.10; Clinical Laboratory Improvement Amendments of 1988 (CLIA); P. L. 100-578 (42 U.S.C. Section 263a); and State Plan, Attachment 3.2-A. Rule effective October 1, 1982. Effective date of this amendment January 14, 1987. Effective date of this amendment May 13, 1993.

Rule No. 560-X-1-.14. Medicaid payments for Medicare/Medicaid and/or Qualified Medicare Beneficiaries (QMB) Eligible Recipients.

Medicaid pays the monthly premiums for Medicare insurance for an eligible Medicare/Medicaid and/or QMB recipient to the Social Security Administration. Medicaid also pays the applicable Medicare Part A and Part B deductibles and/or coinsurance for an eligible Medicare/Medicaid and/or QMB recipient, as specified below.

(1) Definitions

(a) "QMB" recipient is a Part A Medicare beneficiary whose verified income and resources do not exceed certain levels.

(b) "Deductible" is the dollar amount a Medicare eligible must pay for his/her own health care services.

(c) "Coinsurance" is the percentage of each bill a Medicare eligible must pay

under certain conditions, in addition to the deductible amount.

(2) Part A

(a) Medicaid inpatient hospital days run concurrently with Medicare days. The Part A deductible less any applicable copay or coinsurance days are covered Medicaid services, provided the Medicaid covered days for the calendar year have not been exhausted unless the recipient is a QMB. For QMB recipients, the inpatient hospital deductible less any applicable copay, coinsurance days and lifetime reserve days are covered services for any inpatient admission.

(b) Medicaid may pay the Part A coinsurance for the twenty-first (21st) day through the hundredth (100th) day for Medicare/Medicaid and/or QMB eligible recipients who qualify under Medicare rules for skilled level of care. An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the twenty-first through the hundredth day. No payment will be made by Medicaid (Title XIX) for skilled nursing care in a dual certified nursing facility for the first twenty (20) days of care for recipients qualified under Medicare rules.

(c) Medicare pays in full for Medicare-approved home health services, therefore, Medicaid has no liability for these services.

(d) Medicare pays in full for Medicare-approved hospice services, therefore, Medicaid has no liability for these services.

(e) Medicaid covers Medicare coinsurance days for swing bed admissions for QMB recipients. An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the Medicaid swing bed rate, will be paid.

(3) Part B

(a) Except as provided in this subsection, Medicaid pays the Medicare Part B deductible and coinsurance to the extent of the lesser of the level of reimbursement under Medicare rules and allowances or total reimbursement allowed by Medicaid less Medicare payment.

(b) Medicare related claims for QMB recipients shall be reimbursed in accordance with the coverage determination made by Medicare. Medicare related claims for recipients not categorized as QMB recipients shall be paid only if the services are covered under the Medicaid program.

(c) Hospital outpatient claims are subject to Medicaid reimbursement methodology but are not subject to the outpatient limitation of three visits a calendar year.

(d) Medicare claims for rented durable medical equipment shall be considered for payment if the equipment is covered as a purchase item under the Medicaid Program. Rental payments and purchases on noncovered Medicaid items for QMB recipients shall also be considered for payment.

(4) When a Medicaid recipient has third party health insurance of any kind, including Medicare, Medicaid is the payer of last resort. Thus, provider claims for Medicare/Medicaid eligibles and QMB eligibles must be sent first to the Medicare carrier. If Blue Cross and Blue Shield of Alabama is the Medicare carrier, it will forward a crossover claim for deductible and/or coinsurance to Medicaid's fiscal agent for payment. If the carrier is any other company, the claim must be filed with the Medicaid fiscal agent by the provider. The third party insurance chapter of this Code contains additional health insurance information.

(a) Providers will complete the appropriate Medicare claim forms ensuring that the recipient's thirteen (13)-digit Medicaid ID number is on the form. The completed claim shall be forwarded to an Alabama Medicare carrier for payment.

(b) If the provider's claim for service is rejected by the Medicare carrier as "Medicare noncovered service" but is a covered Medicaid service, a Medicaid claim form, completed in accordance with instructions in the Alabama Medicaid Provider Manual, with a copy of the Medicare rejection statement, should be sent to the Medicaid fiscal agent for payment. QMB-Only recipients are not entitled to Medicaid coverage for Medicare noncovered services.

(c) Providers in other states who render Medicare services to Alabama Medicare/Medicaid eligibles and QMB eligibles should file claims first with the Medicare carrier in the state where the service was performed.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: State Plan, Attachment 3.2-A and 3.5-A; 42CFR, Section 431.625; Social Security Act of 1988 (Public Law 100-360); Balanced Budget Act of 1997.
History: Rule effective October 1, 1982. Amended November 10, 1983; March 13, 1984; June 21, 1984; January 8, 1985; April 11, 1986; January 1, 1988; February 1, 1989; May 12, 1989; January 1, 1990; June 14, 1990; February 1, 1996; April 12, 1996; November 10, 1997. Emergency rule filed and effective October 1, 1999. Amended: Filed October 13, 1999; effective; January 12, 2000. Amended: Filed February 19, 2010; effective May 14, 2010.

Rule No. 560-X-1-.15. Out-of-State Care and Services.

(1) Medical care and services provided outside the State of Alabama for Alabama Medicaid recipients are covered services if and only if such services are covered when rendered in-state and are medically necessary.

(a) Medical care and services which require prior authorization for in-state providers will continue to require prior authorization for out-of-state providers, i.e. organ transplants, select surgical procedures. (Refer to Rule No. 560-X-1-.27 and Rule No. 560-X-6-.13 respectively).

(b) Out of state providers must follow the enrollment procedures of the Alabama Medicaid Agency as stated in Rule No. 560-X-7-.02.

Authority: State Plan; Social Security Act, Title XIX, Section 1902(a)(16) & Section 1902(a)(10)(A); 42 C.F.R. Section 431.52. Rule amended effective October 13, 1992

Rule No. 560-X-1-.16. In-State Care and Services.

(1) For each of the several categories of Medicaid covered services there may be state imposed limitations on frequency, amount, type, or kinds of services for which Medicaid will pay. Additional information concerning covered services limitation is found in the program chapters of this code.

(2) Limitations of Medicaid services and supplies may not be absolute. In individual cases of justified medical necessity they may be exceeded if prior approval is obtained from Medicaid. Chapters concerned with covered services explain how to obtain prior approval for services beyond the state's normal limit.

Authority: State Plan, Attachment 3.1-A; 42 C.F.R., Section 440.210 & 441.10; Social Security Act, Title XIX, Section 1902(a)(10)(A).

Rule No. 560-X-1-.17. Providers Claims.

(1) Providers of services and supplies shall be given claim forms by the Medicaid fiscal agent at the time of enrollment.

(2) Providers who prefer to use electronic media claims submission must sign a contract with Medicaid. Electronic media claims submission, includes, but is not limited to, magnetic tape, diskette, or on-line computer. Approved tapes are to be obtained at the provider's expense.

(3) Instructions concerning claim forms completion and processing procedures are contained in the provider manual(s) compiled and distributed to Alabama Medicaid Providers by the fiscal agent.

(4) Time limits for Claim Submission.

(a) Medicaid will pay only clean claims submitted timely to its fiscal agent. A clean claim is a claim which can be processed for payment or denied without obtaining additional information from the provider. A timely claim is a clean claim which is received by the fiscal agent within one year of the date of service, unless a different limitation is specifically provided elsewhere in this Code.

(b) A claim which does not have sufficient information to be entered into the automated claims processing system will be returned to the provider (RTP) and will not be considered as a clean claim submitted timely to the fiscal agent.

(c) A clean claim which is not timely received by the fiscal agent will be denied as outdated, except as provided in paragraph (5) below:

(5) Exceptions to Time Limits for Claims Submission.

(a) Where a claim has been timely submitted to Medicare or other third party payor and the Medicaid claim is not timely received in payable form by the fiscal agent in accordance with paragraph (4), above, a clean claim may still be processed if received within 120 days of the notice date of the disposition by the third party payor with such date indicated on the face of the claim. If Medicare or other third party payor denies the claim, a copy of the denial notice must be attached

(b) Where a claim is for services rendered to a recipient during a time period for which retroactive eligibility has been awarded and the claim is not timely received in payable form in accordance with paragraph (4), above, a clean claim may still be processed if received by the fiscal agent within one year of the date of the award notice.

(c) Where a claim has been paid by Medicaid and is subsequently recouped, a resubmitted clean claim which is not timely received in payable form in accordance with paragraph (4), above, may still be processed if received within 120 days of the recoupment date, with such date indicated on the face of the claim. A copy of the EOP showing the recoupment must be attached.

(d) The agency may make payments at any time in accordance with a court order, or to carry out administrative review or hearing decisions taken to resolve a dispute.

(6) Time Limits for Claims Payments.

(a) Except as otherwise provided above, the Medicaid fiscal agent must process and pay all clean claims within twelve (12) months of receipt of the claim.

(b) A provider who submits a clean claim to the fiscal agent should normally receive payment or denial within ninety (90) days. If payment is not received within this time period the provider should contact the fiscal agent for a status report of the claim.

(c) When a provider's efforts to receive payment for a claim, with the help of the fiscal agent are fruitless, the provider should write to the associate director for its program at Medicaid before the time limitation expires. Providers should contact the Third Party section at Medicaid if there are problems with TPL-related claims.

(7) Administrative Review of Claims Denied as Outdated.

(a) A provider who is denied payment on an outdated claim may request an administrative review of the claim. A written request for an administrative review should be addressed to the appropriate program area and must be received by Medicaid within sixty (60) days of the date the claim becomes outdated, which is the time limit provided in paragraph (4)(a), except that a claim falling within one of the exceptions in paragraphs (5)(a), (b) or (c), above, becomes outdated at the expiration of the 120-day or one-year period, whichever is applicable.

(b) A provider is not entitled to a fair hearing on an outdated claim until after an administrative review of the claim. A hearing request received prior to or in lieu of a request for an administrative review will be treated in all respects as a request for an administrative review.

(c) It is the responsibility of the provider, when submitting outdated claims for an administrative review, to furnish adequate documentation of its good faith attempts to obtain payment of the claim, including copies of relevant EOPs and correspondence with the fiscal agent and Medicaid. The provider must also include an error-free claim to furnish the fiscal agent in cases where the decision is favorable.

(d) Where a provider has timely requested an administrative review, research of the claim history reveals that the claim was originally filed before it became outdated under paragraph (7)(a), and the provider has established that it made a good faith effort to file a clean claim, Medicaid shall have the authority to instruct the fiscal agent to waive the filing limitation and process the claim

(e) The provider will be notified in writing of the review decision. A provider who has timely requested an administrative review and received an adverse decision may request a fair hearing in accordance with Chapter 3 of this Administrative Code. Such request must be in writing and received by Medicaid within 60 days of the date of the administrative review denial letter. A provider is not entitled to further administrative review or a fair hearing on an outdated claim which is processed under this rule and which is denied due to a provider error on the claim.

(f) If all administrative remedies have been exhausted and the claim is denied, THE PROVIDER CANNOT COLLECT FROM EITHER THE RECIPIENT (PATIENT) OR HIS/HER SPONSOR OR FAMILY.

Author: Bill Butler, General Counsel, Office of General Counsel
Statutory Authority: 42 C.F.R. Section 447.45; Social Security Act, Section 1902(a)(27).
History: Rule effective October 1, 1982. Amended April 11, 1985; January 1, 1986; ER April 27, 1987; August 10, 1987; March 12, 1988; May 12, 1989, December 14, 1990 and January 13, 1993. **Amended:** Filed August 21, 2002, effective November 15, 2002.

Rule No. 560-X-1-.18. Provider/Recipient Signature on Claim Forms.

(1) Provider Signatures.

(a) Medical Claims: Individual practitioners may sign a medical claims submission agreement with Medicaid for the submission of paper claims in lieu of signing individual claims forms. By signing the claim agreement, the provider agrees to keep any records necessary to disclose the extent of services the provider furnishes to recipients; to furnish Medicaid, the Secretary of HHS, or the State Medicaid fraud control unit such information and any information regarding payments claimed by the provider for furnishing services, upon request; to certify that the information on the claim is true, accurate, and complete, and that the claim is unpaid; and that the provider understands that payment of the claim will be from federal and state funds, and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws. If an agreement is not signed, the individual practitioner must personally sign the claim form in the appropriate area or place his/her initials next to a typewritten or stamped signature. An individual practitioner's name or initials may be written by another person who has power of attorney from the practitioner to do so.

(b) Institutional Claims: A representative of the institution must sign the UB-82 claim form in the appropriate area or place his/her initials next to a typewritten or stamped signature certifying that the statements on the reverse apply to the bill and are made a part thereof. Nursing facilities and home health agencies filing on a turnaround document must have representative sign the certification block on the statistical page.

(c) Pharmacy Claims: Either the pharmacist's signature, the printed name of the pharmacist or the statement "signature on file" must be placed on the drug claim form as certification that the provider agrees to the statements referenced in (1)(a).

(2) Recipient Signature.

(a) While a recipient signature is not required on individual claim forms, all providers must obtain a signature to be kept on file, e.g., release forms or sign-in sheets, as verification that the recipient was present on the date of service for which the provider seeks payment. Exceptions to the recipient signature are listed below.

1. The recipient signature is not required when there is no personal recipient/provider contact as is usually the case for laboratory or radiology.

2. Illiterate recipients may make their mark, for example, "X" witnessed by someone with their dated signature after the phrase "witnessed by."

3. Interested parties may sign claim forms for recipients who are not competent to sign because of age, mental, or physical impairment.

4. Home Health recipient signatures are obtained on the Home Health certification form which acknowledges services are medically necessary and approved for payment.

5. The recipient signature is not required on the provider multiple listings (Turnaround Document) of nursing facility patients, for claim processing by the fiscal agent. Certification by the provider is indicated by their signature on the statistical page attached to the Turnaround Document when submitted to the fiscal agent.

6. The recipient signature is not required when a home visit is made by a physician. The physician must provider documentation in the medical record that the services were rendered.

7. For services rendered in a licensed facility setting, other than the provider's office, the recipient's signature on file in the facility's record is acceptable.

(b) When payment has been made on claims for which the recipient signature is not available and one of the above exceptions is not applicable, the funds paid to the provider covering this claim will be recovered.

Authority: State Plan, Attachment 4.19-A & D; Alabama State Records Commission; 42 C.F.R. Section 433.32. Rule effective October 1, 1982. Amended May 15, 1983, October 7, 1983, and January 1, 1984. Effective date of this amendment October 12, 1991.

Rule No. 560-X-1-.19. Sales Tax on Medicaid Paid Items.

(1) State and municipal gross sales taxes within Alabama are not to be included in charges for Medicaid covered services, medical supplies and equipment.

(2) Alabama law exempts from any state gross sales taxes all medicines prescribed by physicians when the prescription is filled by a licensed pharmacist, or sold to the patient by the physician, for human consumption or intake.

Authority: Act 81-663 of the Alabama Legislature.

Rule No. 560-X-1-.20. Consent for Health Services for Certain Minors and Others.

Consent for health services for certain minors, and others will be governed by Code of Alabama, 1975, Title 22, Chapter 8.

Authority: Code of Alabama, 1975, Section 22-8.

Rule No. 560-X-1-.21. Provider Medicaid Records Inspection/Audit.

(1) Alabama Medicaid providers shall keep detailed records in Alabama, except as provided in subparagraph (5) Rule No. 560-X-16-.02, that will fully disclose the extent and cost of services, equipment, or supplies furnished eligible recipients. These records will be retained for a period of three (3) years plus the current year.

(2) Providers shall make all such records available for inspection and audit by authorized representatives of the Secretary of Health and Human Services, Alabama Medicaid Agency and other agencies of the State of Alabama. Provider records and operating facilities shall be made available for inspection during normal business hours.

(3) All providers shall, upon either verbal or written request from any agencies listed above, furnish free of charge a copy of any requested record. If the provider has no copies, the provider must allow the person requesting the copy to check out the original for copying. The provider may require that a receipt be given for any original record removed from his premises.

Authority: State Plan, Attachment 4.19-A & D; Alabama State Records Commission; 42 C.F.R. Section 433.32. Rule effective October 1, 1982. Amended May 15, 1983 & October 7, 1983. Effective date of this amendment January 1, 1984.

Rule No. 560-X-1-.22. Authorship of Regulations.

The author of all rules and regulations is the Commissioner of Medicaid, the Head of the Agency.

Authority: Executive Order No. 38, dated March 2, 1981 and Executive Order No. 83, dated September 26, 1977.

Rule No. 560-X-1-.23. Payments.

(1) All payments shall be subject to the availability of appropriated funds for the Alabama Medicaid Program.

(2) Notwithstanding anything in this Code to the contrary, in the event of proration of State Funds available to the Alabama Medicaid program, payment for Medicaid benefits shall be made in accordance with provisions of the Alabama State Plan for Medical Assistance.

Authority: State Plan; Code of Alabama, 1975, Section 41-4-90.

Rule No. 560-X-1-.24. Limitations on Providers.

(1) The Alabama Medicaid Agency will normally enroll providers of covered services and issue provider contracts to new provider applicants who meet the requirements of the Code of Federal Regulations, the licensure and/or certification requirements of the State of Alabama, and the Administrative Code and operating procedures of the Alabama Medicaid Agency.

(2) Providers who have been convicted of fraud will not be considered for contract with the Medicaid Agency.

(3) The Alabama Medicaid Agency may terminate an existing contract of a provider when the Agency determines that during the last fiscal year the provider has provided services to Medicaid-only recipients not exceeding five claims and/or $100.00.

Authority: Title XIX, Social Security Act; 42 C.F.R., Section 431.51, Section 440.230, Section 440.240, Section 442.12(d)(1), Section 447.204, Section 442.10, et seq., Section 431.107, Part 455, Subpart C, and Part 405. Rule effective May 9, 1984. Amended March 11, 1985. Emergency rule effective April 16, 1987. Effective date of this amendment July 10, 1987.

Rule No. 560-X-1-.25. Copayment (Cost-Sharing).

(1) Medicaid recipients are required to pay the designated copayment amount for the following services (including Medicare crossovers):

(a) Physician office visits (including optometric)
(b) Inpatient hospital admissions
(c) Outpatient hospital visits
(d) Rural health clinic visits
(e) Durable Medical Equipment
(f) Medical Supplies
(g) Pharmaceutical

(2) The copayment amount does not apply to services provided for the following:

(a) Pregnancy
(b) Recipients under 18 years of age
(c) Family planning
(d) Emergencies
(e) Nursing Home Residents
(f) American Indians

(3) In addition to the exemptions in (2) above, each service has other specific exemptions. Please refer to the appropriate chapter for a complete list of the exemptions.

(4) A provider may not deny services to any eligible individual due to the individual's inability to pay the cost-sharing amount imposed.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: State Plan, Attachment 4.18-A; Title XIX, Social Security Act; 42 C.F.R. Section 447.50, Section 447.55, Section 447.15.
History: Rule effective June 8, 1985. Amended: Filed October 20, 2010; effective February 22, 2011.

Rule No. 560-X-1-.26. Ancillary Services Associated with Noncovered Benefits.

(1) When a medical benefit is a noncovered service under the Alabama Medicaid Program, all ancillary charges related to delivery of that benefit are also considered noncovered.

Authority: State Plan, Title XIX of the Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective February 20, 1986.

Rule No. 560-X-1-.27. Organ Transplants

Alabama Medicaid will cover organ transplants under the following terms and conditions. These terms will apply to all procedures except cornea transplants.

(1) Transplants must be performed in the state of Alabama if medically available and appropriate for particular patient and transplant type with the exception of (8)(d) below.

(2) All transplant candidates must be from referrals by EPSDT or the primary physician.

(3) All transplant evaluations must be conducted by the Medicaid primary contractor. If the primary contractor is unable to perform the transplant, a referral to another facility may be made. The primary contractor will be responsible for coordination and reimbursement of referrals.

(4) The following transplants are covered for recipients of any age:

(a) bone marrow,
(b) kidney,
(c) heart,
(d) lung,
(e) heart/lung,
(f) liver,
(g) pancreas,
(h) pancreas/kidney,
(i) liver/small bowel,
(j) small bowel

(5) For EPSDT referrals, other transplants may be considered for approval if medically necessary, therapeutically effective, and nonexperimental.

(6) All transplants must be prior approved by Medicaid. The primary contractor will forward a recommendation packet to Medicaid following evaluation of the recipient. Medicaid will issue notice to the recipient of approval or denial.

(7) Recipients who are denied Medicaid coverage for transplants will be offered the opportunity for a fair hearing under the provisions of Chapter Three of this code.

(8) Reimbursement

(a) Reimbursement will be a global payment established by Medicaid. The global payment will include the following:

1. pre-transplant evaluation,
2. organ procurement,
3. hospital room, board, and ancillary services,
4. out of hospital ancillary services,
5. post-operative care,
6. pharmacy and laboratory services, and
7. all professional fees.

(b) Services provided after discharge will be reimbursed on a fee for service basis.

(c) Reimbursement provisions apply to transplants performed both instate and out-of-state. The global payment represents full payment for all services associated with the transplant. Recipients may not be billed for the difference between the submitted amount and the global payment.

(d) Third Party Payors: Medicaid is a payor of last resort. When a primary payor other than Medicaid has obligated to cover the transplant Medicaid may, at its discretion, approve that payor's site preference for the transplant.

(9) Cornea transplants are covered for defects (as diagnosed by ophthalmologists) which are correctable by transplant.

(10) Cornea transplants do not require prior approval.

(11) Reimbursement for cornea transplants will be normal Medicaid pricing methodology.

(12) Services associated with cornea transplants will be counted in a recipient's regular Medicaid benefit limits.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: Title XIX, Social Security Act; 42 CFR, Section 405.310(k), Section 440.10, Section 440.50, et seq; State Plan, Attachment 3.1.E and Attachment 4.19B, Section18.
History: Rule effective June 10, 1987. Amended July 17, 1991; October 12, 1991; May 13, 1996; January 12, 1998; and January 11, 1999. Amended: Filed October 20, 1999; effective January 12, 2000. Amended: Filed May 22, 2000; effective August 10, 2000. Amended: Emergency Rule filed January 19, 2000; effective February 1, 2001. Amended: Filed January 19, 2001; effective April 18, 2001. Amended: Filed July 20, 2001, effective October 16, 2001.

Rule No. 560-X-1-.28 Early and Periodic Screening, Diagnosis and Treatment.

(1) Early and Periodic Screening, Diagnosis, and Treatment will be available for Medicaid-eligible recipients under the age of 21 years old. This coverage will be provided for medically necessary health care, diagnosis, treatment and/or other measures described in Section 1905(a) of the Social Security Act and more specifically in Chapter 11 of the Administrative Code.

(2) The services must be necessary to correct or ameliorate a defect, physical or mental illness, or other conditions discovered during or as a result of an EPSDT screen, whether or not the services are covered or exceed benefit limits as stated in the State Plan. Misspent funds identified as a result of retrospective review will be recouped in accordance with the procedures in Chapter 4 of the Administrative Code.

Authority: State Plan, Attachment 3.1-A, Title IX, Social Security Act Section 1905, 42 CFR 440,441. OBRA-89 Section 6403. Rule effective December 14, 1990.

Rule No. 560-X-1-.29 Managed Care.

Medicaid services offered by Managed Care Plans will be available for Medicaid recipients residing in areas of the State targeted for managed care implementation. The Managed Care Plan must cover all services as specified in the contract between the Agency and the Plan and shall not be less in amount, duration and scope, than those available to other Alabama Medicaid eligibles, as specified in the Alabama State Plan for medical assistance.

If an enrollee utilized a Plan's non-contract provider for in-plan services, other than emergency services, family planning services, and services provided by an FQHC, the Plan shall not be liable for the cost of such utilization unless the Plan referred the enrollee to the non-contract provider or authorized the out of Plan utilization. Payment by the referring Plan for

properly documented claims shall not exceed the maximum fee-for-service rates applicable for that provider for similar services rendered under the Alabama Medicaid Program, unless otherwise agreed upon by the Plan and the Plan's non-contract provider. No reimbursement shall be available directly from Medicaid for in-plan services provided by the Plan's non-contract providers.

Authority: 42 C.F.R. Section 447.15. Effective date of this amendment: August 12, 1994.

Chapter 2. Assuring High Quality Care

Rule No. 560-X-2-.01. Methods for Assuring High Quality Care

The following methods shall be used in administering the Medical Assistance Program to ensure that medical remedial care, and service provided are of high quality, properly utilized and based on acceptable professional medical standards, State and Federal laws and regulations.

(1) Peer Review Committees, as appropriate, will be established in Alabama for the purpose of settling disputes related to charges made for professional and other medical assistance services. Problems submitted to Peer Review Committees may originate with Alabama Medicaid Agency, its fiscal agent, providers, and recipients. Additional Peer Review Committees may be established as needed.

(a) Problem referral procedure.

1. The fiscal agent shall gather information about a problem discovered through claims processing and attempt to resolve it with a provider or recipient.

2. Where a solution cannot be reached, the facts will be submitted to the Alabama Medicaid Agency for resolution.

3. Problems not resolved by the Alabama Medicaid Agency may be referred to the appropriate peer review committee. Medicaid will assemble the facts and arrange for the Peer Review Committee to consider the problems at a mutually agreeable time and place. When a professional specialty consultation is needed, Medicaid may arrange for the service.

(b) Facts about Peer Review Committees.

1. Peer Review Committees act independently of fiscal agent and representatives of the Alabama Medicaid Agency.

2. No member of a Peer Review Committee who has an ownership interest in a facility under review will participate in committee action for the facility.

3. A member of a Peer Review Committee shall not review a case on which he or a partner or associate is the attending physician or dentist or in which he has had a professional responsibility.

4. Peer Review Committees may be provided with advice and consultation from other medical and paramedical specialty agencies organized to deal with problems within their specialty.

5. A majority of the members of the committee will constitute a quorum.

6. Peer Review Committees will send their reports to the Deputy Commissioner Program Administration, Alabama Medicaid Agency. Information and reports are releasable on a need-to-know basis.

7. A decision made by a Peer Review Committee is final and binding on all parties if approved by the Director, Programs, Alabama Medicaid Agency.

(c) Pharmacy Peer Review Committees.

See Chapter 16: Pharmacy Services: Rule 560-X-16-.23, Rule 560-X-16-.24, and Rule 560-X-16-.25.

(d) Optometric Peer Review Committee.

1. An optometric Peer Review Committee will be maintained in the state by Medicaid.

2. The committee shall meet at least twice each calendar year to discuss problems and complaints relative to optometric services within the Alabama Medicaid Program.

3. The Committee shall function as an appeal body on the request of Medicaid, optometric providers, and Medicaid recipients.

4. Prior authorization requests from optometrists denied by Medicaid shall be submitted for consultation to the peer review committee before a final determination is made.

(2) Utilization Review.

Each agency, organization, or institution providing care or services in the Medicaid program, must have a utilization review plan approved by Medicaid or its designated agent.

(a) Medicaid or its designee will monitor facility utilization review activities on inpatient hospital and extended care services.

(b) Utilization review for dental services is a part of the dental professional review program.

(c) Medicaid monitors utilization review activities concerned with evaluation and supervision of nursing and other services provided by home health agencies.

(d) Utilization review for Pharmaceutical services is a part of the pharmacy professional review program and monitored by the Drug Utilization Review Program in cooperation with the fiscal agent. Other monitoring activities are carried out by Medicaid in cooperation with the fiscal agent.

(e) Medical review for hospitals will be the responsibility of Medicaid or its designee.

(f) Medical review for skilled and intermediate care nursing facilities, to include ICF/MR and ICF/MD, is the responsibility of the Alabama Medicaid Agency.

(3) Medical Care Advisory Committee.

(a) The State Plan established the requirement for a State Medical Care Advisory Committee to participate with the Commissioner in policy development and program administration, including the seeking of recipient participation in the Alabama Medicaid Program.

(b) The Commissioner shall arrange for committee representation from licensed physicians and others from the health and medical care professions familiar with the medical needs of low income population groups. Representatives of consumer groups and an Indian Tribal Member designee shall be included on the committee.

(c)The State Health Officer and the Commissioner, Department of Human Resources shall be permanent ex-officio members of the committee.

(d)The Medical Care Advisory Committee shall meet semi-annually and at other times as required to advise the Commissioner on medical assistance matters brought before it.

(4) Physician's Task Force:

(a) Medicaid established a Physician's Task Force to obtain input from physicians and physician type providers regarding identification of problems and possible initiatives Medicaid might consider to enhance its relationship with providers.

(b) The commissioner shall arrange for committee representation from licensed physicians and dentists who are familiar with the medical needs of low income population groups.

(c) The State Health Officer and the Executive Director of the Medical Association of the State of Alabama shall be permanent ex-officio members of the Committee.

(d) The Physician's Task Force shall meet semi-annually and at other times as required to advise the commissioner on medical assistance matters brought before it.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: State Plan; 42 C.F.R. Sec. 401, et seq.
History: Rule effective October 1, 1982. Amended, May 9, 1984, October 12, 1995. Filed December 20, 2010; effective March 18, 2011.

Chapter 3. Fair Hearings

Rule No. 560-X-3-.01. Fair Hearings - General

1. The State Plan provides that the office of the Governor acting through Medicaid, will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under Title XIX. An opportunity for a fair hearing shall be granted to any individual or provider of services requesting a hearing because a claim for medical assistance or payment for services provided a recipient is denied or is not acted upon with reasonable promptness, or because the party is aggrieved by any other agency action regarding receipt of medical assistance or payment for services, or by an agency policy as it affects the situation, except as noted in paragraphs 3 and 4 below.

2. The Hearing Authority for all recipient and provider fair hearings for Alabama Medicaid Agency is the Commissioner, who shall appoint one or more Hearing Officers, to conduct fair hearings and submit findings and recommendations to the Commissioner for final decision on each case. The Hearing Officer must not have been involved in any way with the action in question.

3. In general, eligibility for Medicaid is based on eligibility for certain public assistance programs administered by the Department of Human Resources, and the Social Security Administration. Complaints concerning eligibility matters shall be referred to the appropriate agency which made the eligibility determination for a hearing. Procedures shall be set by the hearing agency.

4. Matters pertaining to hospital or nursing home decertification for both Title XVIII and XIX will be referred to the Federal Health and Human Services Director for Health Standards and Quality in Region IV. His office is responsible for making final decisions on joint program decertification.

Authority: State Plan; Title XIX of the Social Security Act. Rule effective October 1, 1982. Effective date of amendment June 23, 1983.

Rule No. 560-X-3-.02. Fair Hearings - Definitions

1. A fair hearing is a face-to-face hearing by an impartial State Hearing Officer at a time and place reasonably convenient for the complainant and attended by the complainant or his authorized representatives who may call witnesses or examine witnesses called by others.

2. A Documentary Hearing is one in which all the evidence for both the complainant and the agency is presented to the hearing officer in written form. He then makes his recommendations based on the evidence presented. Recommendations and decisions in documentary hearings have the same authority as those rendered in a face-to-face hearing.

Authority: Section 1902(a)(3), Title XIX of the Social Security Act; 42 CFR Sec. 431.200 thru 431.245 and Section 41-22-12, Alabama Administrative Procedure Act. Rule effective October 1, 1982. Amended August 9, 1984, and January 1, 1986. Effective date of this amendment August 10, 1987.

Rule No. 560-X-3-.03. Fair Hearing Procedures for Recipients and Providers

1. The procedures contained herein have been adopted by Medicaid to settle formal complaints of persons who are receiving care under the Medicaid program or who have been denied care under this program because of eligibility standards, or for providers who desire a fair hearing upon denial of a claim for services, out-dated claim and non-renewal or termination of a contract. At the request of a provider, the Commissioner may grant a fair hearing on any other matter pertinent to Medicaid.

2. Except where the Secretary of Health and Human Services had determined that a provider must be removed from the program for abuse, the Commissioner of Medicaid shall, in writing, offer a provider a fair hearing prior to suspension or termination from the Alabama Medicaid Program. If the provider does not respond within 10 days of the written offer he will be terminated from the program without further action.

3. When provider criminal fraud is suspected, the Commissioner shall cause her/his appropriate staff to consult with the Office of the Attorney General prior to offering a fair hearing for termination purposes.

4. A complainant, or authorized person acting for him, may request a fair hearing in writing if he is not satisfied with actions taken that relate specifically to himself. Persons desiring a hearing within the jurisdiction of Medicaid will be referred to the Director, Hearings, for appropriate scheduling.

5. Except for the specific situations outlined below a written request for a fair hearing must be received by Medicaid within 60 days following the notice of action which prompts a claimant to request a hearing. Medicaid will not accept requests for fair hearings which are outside the 60 day limit. The exceptions to the 60 day limit are as follows:

    a. In a case in which Medicaid is terminating recipient eligibility, if a hearing request is received within 10 days of the date of the notice of action, benefits may be continued pending outcome of the hearing unless there are unnecessary delays in finalizing the hearing caused by the recipient or the recipient's representative.

    b. In a case in which Medicaid is suspending or terminating a Medicaid provider, if a hearing request is received within 10 days of receipt of the notice of termination, the provider may continue to remain as a Medicaid provider pending outcome of the hearing, unless there are unnecessary delays in finalizing the hearing caused by the provider or the provider's representative.

Authority: State Plan, Title XIX of the Social Security Act. 42 C.F.R. Sec. 401, et seq. Rule effective October 1, 1982. Amended April 11, 1985. Effective date of amendment January 1, 1986.

Rule No. 560-X-3-.04. Fair Hearing Procedures

1. A hearing shall be impartially conducted and held at a time and place which is reasonably convenient for the parties, and written notice of such time and place shall be given by the Director, Hearings, or the designated Hearing Officer, at least 10 (10) calendar days before the hearing is to be held. This written notice will also contain information explaining the complaint's rights and procedures regarding a hearing.

2. A complainant may be represented or assisted by legal counsel at his own expense; he may have a friend or relative present his case; or he may present his case himself.

3. A complainant or his representative must attend his hearing unless he is given written permission by appropriate authority to be absent. His failure to attend shall leave the Hearing Officer with no alternative but to proceed with the hearing and render a conclusion and recommendation in his absence based upon evidence presented by he Alabama Medicaid Agency representatives.

4. The complainant and/or his authorized representative may call witnesses, and may examine witnesses called by others.

Authority: Section 1902(a)(3), Title XIX, Social Security Act; 42 CFR, 431.200 thru 431.245, and Section 41-22-12, Alabama Administrative Procedure Act. Rule effective October 1, 1982. Effective date of amendment August 9, 1984.

Rule No. 560-X-3-.05. Documentary Hearing Procedures

Documentary Hearings are based solely upon the written or printed evidence presented to the Hearing Officer by both the complainant and the agency. Complainants should, therefore, submit complete records of all claims filed, correspondence, rejections, forms and attachments at the time the original written request for a hearing is forwarded to the agency.

Authority: State Plan, Title XIX of the Social Security Act. 42 C.F.R. Section 401, et seq. Rule effective August 10, 1987.

Rule No. 560-X-3-.06. Action by Agency On Hearing

1. Prompt, definitive, and final administrative action will be taken within sixty (60) days between the request for a hearing and the rendering of the decision, unless there are extenuating circumstances that require additional time. If the hearing is not completed within sixty days, the recipient or provider will be notified of the reason for the delay. In any event, final administrative action will be taken within ninety (90) days from the date of request for a hearing. The complainant will receive written notification of the decision.

2. Recommendations of the Hearing Officer shall be based exclusively on evidence and other material introduced at the hearing. A verbatim transcript of testimony and exhibits, or an official report by the Hearing Officer containing the substance of what transpired at the hearing, together with all papers and requests filed in the proceeding and the Hearing Officer's recommendations, shall constitute the exclusive record for decision on a live hearing and shall be available to the complainant at any reasonable time. The storage, proper maintenance and security of such records shall be the responsibility of the Director, Hearings, Alabama Medicaid Agency.

3. Adverse decisions approved by the Commissioner, as the hearing authority, shall contain a statement that rehearing and/or judicial review of this decision is available pursuant to the provisions of the Alabama Administrative Procedure Act. The Commissioner shall notify the requestor, in writing regarding the hearing decision.

Authority: Section 1902(a)(3), Title XIX of the Social Security Act; 42 CFR, Sec. 431.200 thru 431.245, and Section 41-22-17, Alabama Administrative Procedure Act. Rule effective October 1, 1982. Amended August 9, 1984. Effective date of amendment January 1, 1986.

Rule No. 560-X-3-.07. Denial of a Hearing

1. If the request for a hearing, in the opinion of Medicaid legal counsel, presents only a legal issue, and the validity of the controlling law or regulation is not challenged in the hearing request, a fair hearing request may be denied.

2. If eligibility of a provider or a recipient has been terminated because of a criminal conviction for Medicaid fraud or abuse, or if a provider has been terminated because of loss of required licensure, then no fair hearing need be given. A certified copy of the judgement of conviction or of the decision to revoke or suspend a provider's license shall be conclusive proof of ineligibility for further participation in the Medicaid Program. The pendency of an appeal for any such conviction or license revocation or suspension shall not abate the termination of Medicaid eligibility. If a conviction, or license revocation or suspension is reversed on appeal, the recipient or provider may apply for reinstatement to the Medicaid program. However, the reasons for the reversal will be scrutinized by Medicaid and reinstatement will be at the sole discretion of the Commissioner.

Authority: State Plan, Title XIX of the Social Security Act. 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982.

Chapter 4. Program Integrity Division

Rule No. 560-X-4-.01. General

1. The Program Integrity Division is responsible for planning, developing, and directing Agency efforts to identify, prevent, and prosecute fraud, abuse and/or misuse in the Medicaid Program. This includes verifying that medical services are appropriate and rendered as billed, that services are provided by qualified providers to eligible recipients, that payments for those services are correct, and that all funds identified for collection are pursued.

2. Federal regulations require the State Plan for Medical Assistance to provide for the establishment and implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess payments. The Alabama Medicaid Agency (Medicaid) has designated the Program Integrity Division through its Provider Review, Recipient Review, and Investigations Units to perform this function. These units are responsible for detecting fraud and/or abuse within the Medicaid Program through reviewing paid claims history and conducting field reviews and investigations to determine provider/recipient abuse, deliberate misuse, and suspicion of fraud. In addition, these units are utilized to aid in program management and system improvement.

3. Cases of suspected recipient fraud are referred to local law enforcement authorities for prosecution upon completion of investigation. Cases of suspected provider fraud and patient abuse are referred to the Medicaid Fraud Control Unit in the Alabama Attorney General's Office which was established under Public Law 95-142 and Health and Human Services guidelines to investigate, for possible prosecution, alleged provider fraud and patient abuse in the Medicaid Program.

4. The Utilization Review Committee (URC) is established under the authority of Code of Alabama (1975) Section 22-6-8. This Committee reviews cases of suspected provider or recipient fraud or abuse and recommends appropriate sanctions. (Refer to sections 560-X-4-.04 and 560-X-4-.05.)

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Parts 431, 455, 456, 1000, 1001, 1002, State Medicaid Manual 11420.6M. Rule effective October 1, 1982. Amended November 10, 1988. Effective date of this amendment March 15, 1994.

Rule No. 560-X-4-.02. Purpose

The purpose of the Program Integrity Division is:

1. To guard against abuse, fraud, and deliberate misuse of Medicaid program benefits by individual providers and recipients;

2. To assure that Medicaid recipients receive necessary medical care at a level of quality consistent with that available to the general population;

3. To exercise necessary fiscal control over federal and state tax dollars;

4. To assure provider and recipient compliance with federal and state Medicaid rules and regulations; and

5. To assist in the identification of claims processing procedures that may be in conflict with State policy.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Parts 431, 455, 456, 1000, 1001, 1002, State Medicaid Manual 11420.6M. Rule effective October 1, 1982. Amended November 10, 1988. Effective date of this amendment March 15, 1994.

Rule No. 560-X-4-.03. Method

1. Acquire, organize, and analyze data.

2. Present computer results through special reports that will enable Program Integrity to accomplish the following:

    a. Develop a comprehensive statistical profile of health care delivery and utilization patterns.

    b. Reveal suspected instances of potential fraud or abuse by individual practitioners, providers, recipients, or sponsors of recipients.

    c. Provide information indicating the existence of any potential defects in the level of care or quality of services provided under the Medicaid Program.

    d. Provide information indicating the existence of any potential defects in State resolution procedures.

3. Conduct in-house and on-site reviews/investigations to obtain additional facts and/or evidence to substantiate suspicions or allegations. Alabama Medicaid Investigators shall properly identify themselves to providers or recipients as representing the Alabama Medicaid Agency. They shall request information that they consider pertinent to the investigation. Requests shall be made directly to the provider, administrator, or person designated in charge.

4. Prepare and present reviews/investigation findings for corrective action and/or sanction.

5. Provide information identifying defects in documented policy and intended application.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. §401, 431 et seq., 455 et seq., 456 et seq., State Medicaid Manual 11420.6M. Rule effective October 1, 1982. Amended November 10, 1988, and March 15, 1994. Effective date of this amendment March 26, 1996.

Rule No. 560-X-4-.04. Fraud and Abuse by Providers

1. Fraud is defined as an intentional deception or intentional misrepresentation made by a person with the knowledge that the deception could result in some unauthorized personal benefit or unauthorized benefit to some other person. Fraud is dependent upon evidence that must substantiate misrepresentation with intent to illegally obtain services, payment, or other gains.

2. Code of Alabama (1975) Section 22-1-11 makes it a felony offense to falsify a claim or application for payment of Medicaid benefits or offer, pay, solicit or receive kickbacks, bribes, or rebates for services. Convictions for any of these felonious actions could result in a fine of $l0,000 or imprisonment for one to five years for each violation.

3. Providers participating in the Alabama Medicaid Program shall make available, free of charge, the necessary records and information to Medicaid investigators, members of the Attorney General's staff, or other designated Medicaid representatives who, in the course of conducting reviews or investigations, have need of such documentation to determine fraud, abuse and/or other deliberate misuse of the Medicaid program.

4. The Medicaid Fraud Control Unit of the Attorney General's Office may refer providers to Medicaid for administrative sanctions because:

    a. The dollar amount of the fraud involved does not warrant the expense of prosecution; or

    b. Evidence of willful intent to defraud is lacking, although evidence of abuse is present.

5. Program abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services which are not medically necessary or that fail to meet professionally recognized standards for health care; provided however, that any finding by the state survey agency of non-compliance by a nursing facility with conditions of participation shall not be considered program abuse under this definition or the examples below. Remedies for such non-compliance are governed by Rule 560-X-l0-.25 of this Code. Nothing in this definition is intended to imply that disputes arising from routine provider reviews or audits necessarily constitute program abuse. Following are some examples of program abuse as defined by the Alabama Medicaid Agency:

    a. Over-utilizing the Medicaid program by furnishing, prescribing, or otherwise causing a recipient to inappropriately receive service(s) or merchandise which is not medically necessary or not otherwise required or requested by the recipient, or not generally provided private pay patients;

    b. Receiving disciplinary action by any state licensing authority which restricts or modifies a provider's license;

    c. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral;

    d. Submitting a false application for provider status;

    e. Charging recipients for services over and above that paid for by Alabama Medicaid Agency;

    f. Failing to correct deficiencies in provider operations after receiving written notice of these deficiencies from Medicaid;

    g. Failing to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments received from the Medicaid fiscal agent; or

    h. Being in a status of less than good standing with a professional licensing, peer review, or similar organization governing the provider's practice.

6. The following types of administrative sanctions may be imposed as a result of program abuses or fraud by providers:

    a. Provider warning letters for those instances of abuse that can be satisfactorily settled by an informal correspondence process;

    b. Suspension of payments to a provider in accordance with 42 C.F.R. 455.23 upon receipt of reliable evidence (such as indictment or similar legal action) that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program;

    c. Suspension of payments when a provider does not voluntarily repay improper payments; or for large repayments which have been scheduled for installments, or withholding payments of pending claims, as well as future claims, for application to overpayments owed;

    d. Review of provider's claims prior to payment;

    e. Restriction of provider's Medicaid participation to a specified setting or specified conditions;

    f. Suspension of provider's Medicaid participation for a specified time period; and/or

    g. Termination of provider's Medicaid participation.

7. Restitution of improper payments made to the provider by the Medicaid program may be pursued in addition to any administrative sanctions imposed.

8. The decision as to the sanction to be imposed shall be at the discretion of the Deputy Commissioners of Medicaid based on the recommendation(s) of the Utilization Review Committee and/or the written policy of the Program Integrity Division.

9. The following factors shall be considered in determining the sanction(s) to be imposed:

    a. Seriousness of the offense(s);

    b. Extent of violations and history of prior violations;

    c. Prior imposition of sanctions;

    d. Provider willingness to obey program rules;

    e. Actions taken or recommended by peer review groups or licensing boards; and

    f. Effect on health care delivery in the area.

10. Medicaid shall initiate proceedings to suspend or terminate any provider that has been:

    a. Convicted of defrauding the Medicaid program or convicted of a crime related to delivery of medical care or services;

    b. Suspended or terminated from the Medicare program for fraud/abuse; or

    c. Suspended or terminated from practice by his professional licensing authority.

11. An administrative sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances.

12. Suspension or termination from participation of any provider shall preclude Medicaid from making payment for any item or service furnished by or at the medical direction or on the prescription of such provider on or after the effective date of the exclusion when a person furnishing the service knew, or had reason to know, of the exclusion.

13. No clinic, group, corporation, or other association which is a provider of services shall submit claims for payment to the fiscal agent for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program, except for those services or supplies provided prior to the suspension or termination.

14. When a provider has been sanctioned, Medicaid shall notify, as appropriate, the applicable professional society, licensing authority, the Attorney General's Medicaid Fraud Control Unit, federal agencies, appropriate county departments of social services, and the general public of the sanctions imposed.

15. A notice setting forth the violations and the provider's rights to an administrative hearing shall be sent to the provider at least ten days prior to the effective date of such sanction except for sanctions as listed in (6)(a) and (b).

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Parts 401, 431, 455, 456, State Medicaid Manual 11420.6M. Rule effective October 1, 1982. Amended December 10, 1987; November 10, 1988; March 15, 1994; and March 26, 1996. Effective date of this amendment June 11, 1996.

Rule No. 560-X-4-.05. Abuse, Fraud, and/or Deliberate Misuse by Recipients or Sponsors of Recipients

1. Recipient abuse, deliberate misuse, or fraud cases include, but are not limited to, the following categories:

    a. Drug overutilization or overutilization of services;

    b. Sale, alteration, or lending of the Medicaid card to others for services;

    c. Criminal activity involved in securing medical services (such as forged prescriptions);

    d. Repeated failure to safeguard the Medicaid card;

    e. Collusion with providers for services or supplies;

    f. Providing incorrect information or allowing others to do so in order to obtain Medicaid eligibility;

    g. Failure to reveal to Medicaid the existence of third party insurance, failure to pay to Medicaid funds received from "Third Parties" as required by Chapter 20 of these Codes, or failure in other respects to cooperate with Medicaid in its effort to secure the State's subrogation rights; or

    h. Failure to report changes which occur in income, living arrangements, or resources.

    i. Inappropriate use of Medicaid voucher payments through the Non-Emergency Transportation Program.

2. Code of Alabama (l975) Section 22-6-8 requires that a Medicaid recipient who has abused, defrauded or deliberately misused benefits of the program shall immediately become ineligible for Medicaid benefits and shall not again be eligible for Medicaid services for a period of not less than one year and until full restitution is made to the State of Alabama.

3. All cases of suspected abuse, misuse or fraud in receipt of Medicaid benefits by a recipient or sponsor shall be reviewed by the Program Integrity Division to determine the validity of suspected abuse, misuse, or fraud. This determination shall include but not be limited to review of system and/or medical data, and if necessary, interview of the suspect recipient, providers with whom he has been in contact, and others as necessary.

4. Corrective action for suspected fraud, abuse, or deliberate misuse shall include the following:

a. A warning letter for recipients found to be marginally abusing drugs or other services;

b. Restriction of benefits to one physician and one pharmacy for recipients found to be overutilizing, misusing, and/or abusing services;

c. Additional restriction of controlled substances if Agency medical staff determines that a recipient's controlled substances utilization is not supported by medical diagnoses; or

d. Suspension of Medicaid benefits as authorized by Code of Alabama (l975) Section 22-6-8, if recommended by the URC and approved by the Deputy Commissioners of Medicaid. Initial determinations of fraud, abuse, or deliberate misuse of program benefits may result in URC recommendation to the Deputy Commissioners of Medicaid that the recipient be deemed ineligible for Medicaid benefits for a period of not less than one year and until full restitution of any misspent funds resulting from such fraud, abuse or deliberate misuse. A second determination of fraud, abuse, or deliberate misuse of program benefits by a recipient may result in a URC recommendation to the Deputy Commissioners of Medicaid that the recipient be deemed ineligible for Medicaid benefits for a period of not less than two years and until full restitution has been made. Recurring occurrences of fraud, abuse, or deliberate misuse of program benefits may result in a URC recommendation to the Deputy Commissioners of Medicaid that the recipient be deemed ineligible for Medicaid benefits for a period of not less than four years and until full restitution has been made.

5. At least ten days prior to imposing any administrative sanction for fraud, abuse or intentional misuse, the recipient shall be provided with a notice of violation setting forth the reasons for the sanctions and the recipient's rights to an administrative hearing.

6. When a recipient's eligibility for Medicaid benefits has been suspended due to having committed fraud, abuse, or deliberate misuse of Medicaid benefits and the recipient subsequently reapplies for Medicaid benefits during the period of suspension due to pregnancy, the Director of Program Integrity will change the suspended status of the recipient to a restricted status for pregnancy related services only. The recipient's eligibility status will be changed back to suspended at the end of the month in which the sixtieth day following delivery occurs.

7. Recipients placed on restriction will have their utilization of services reviewed at least annually to determine if there has been a change in utilization of drugs or other services. When the determination has been made by medical staff that a restriction status should be continued, the recipient will be notified of the following:

   a. The reason for continuation of their restriction status;

   b. Their right to reconsideration of this decision and procedures for requesting such; and

   c. Their right to a fair hearing and procedures for requesting such.

8. If a recipient loses eligibility while on restriction, they will remain restricted upon reinstatement of eligibility pending review by Medicaid medical staff.

Author: Arnita Howard, Director, Beneficiary Support Division
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Sections 401, 431.54, 455 et seq., 456 et seq., 6th Omnibus Budget Reconciliation Act, Sec 9401, 9407.
History: Rule effective October 1, 1982. Amended February 8, 1984; June 10, 1987; April 12, 1988; November 10, 1988; March 14, 1989; October 13, 1989; June 14, 1990; January 13, 1993; March 15, 1994; and March 26, 1996. Amended: Filed December 16, 2002; effective March 18, 2003.

Rule No. 560-X-4-.06. Medicaid Eligibility Quality Control

The Alabama Medicaid Agency Quality Control Unit is responsible for monitoring Medicaid eligibility correctness. Through its findings administrators may identify and eliminate or reduce dollar losses by effective corrective action in program operations.

1. Quality Control shall select a monthly random sample of Medicaid recipients from the computer maintained eligibility file.

2. The random sample shall be reviewed for eligibility determination errors, policy application, and administrative correctness.

3. Claims shall be collected on the sample to determine payment and error rate due to eligibility determination errors.

4. Information gathered from these reviews shall provide the basis for corrective action to reduce erroneous Medicaid payments.

5. The Department of Human Resources (DHR) has eligibility quality control responsibility for the Aid to Dependent Children (AFDC) Program and state supplementation segment of Medicaid eligibles.

6. The total Medicaid payment error rate is the amount of erroneous claims paid due to client ineligibility in the medical assistance only (MAO), AFDC related, and state supplementation cases.

Authority: State Plan; 42 C.F.R. Sec. 401, et seq. Rule effective October 1, 1982. Amended May 9, 1984. This amendment effective September 12, 1995.

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Chapter 5. Psychiatric Facilities for Individuals 65 or Over

Rule No. 560-X-5-.01. General

1. Inpatient psychiatric services for recipients age 65 or over, are covered services when provided:
    a. In a free-standing psychiatric hospital exclusively for the treatment of persons age 65 or over with serious mental illness(as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition);
    b. Under the direction of a geriatric psychiatrist;
    c. After the recipient reaches the age of 65; and
    d. To a patient remaining in a facility for the course of the hospitalization.
2. Inpatient psychiatric services for recipients age 65 and over are unlimited if medically necessary and the admission and/or the continued stay reviews meet the approved psychiatric criteria. These days do not count against the recipient's inpatient day limitation for care in an acute care hospital.

Authority: State Plan, Attachment 3.1-14. Rule effective October 12, 1995.

Rule No. 560-X-5-.02. Participation

1. In order to participate in the Title XIX Medicaid program and to receive Medicaid payment for inpatient services for individuals 65 and older, a provider must meet the following requirements:
    a. Be certified for participation in the Medicare/Medicaid program;
    b. Be licensed as an Alabama free-standing acute geriatric psychiatric hospital in accordance with current rules contained in the Alabama Administrative Code Chapter 420-5-7. State hospitals that do not require licensing as per state law are exempt from this provision (Alabama Code, Section 22-50-1, et seq.);
    c. Be accredited by the Joint Commission on Accreditation of Healthcare Organizations;
    d. Specialize in the care and treatment of geriatric patients with serious mental illness;
    e. Have on staff at least one full-time board certified geriatric psychiatrist/geriatrician;
    f. Employ only staff who meet training/certification standards in the area of geriatric psychiatry as defined by the State's mental health authority;
    g. Be recognized as a teaching hospital, and affiliated with at least one four-year institution of higher education with a multi-disciplinary approach to the care and treatment of geriatric patients with serious mental illness;
    h. Provide outpatient and community liaison services throughout the State of Alabama directly or through contract with qualified providers;
    i. Be in compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act;
    j. Execute an Alabama Medicaid Provider Agreement for participation in the Medicaid program;
    k. Submit a written description of an acceptable utilization review plan currently in effect;

l. Submit a budget of cost for its inpatient services for its initial cost reporting period, if a new provider; and

m. Be under the jurisdiction of the State's mental health authority.

2. Application by Alabama geriatric psychiatric facilities for participation in the Alabama Medicaid program is to be made to:

   Alabama Medicaid Agency
   Attention: Hospital Program
   Post Office Box 5624
   Montgomery, Alabama 36103-5624

3. After enrollment, submission of a monthly inpatient census report using the PSY-4 form is required.

4. It is the facility's responsibility to ensure compliance with all federal and state regulations and to ensure that all required documentation is included in the recipient's record. Failure to comply will result in denial of payment and possible recoupment of reimbursements made previously.

Authority: 42 C.F.R. Subpart E, Section 482.60 through Section 482.62. Rule effective October 12, 1995. The effective date of this amendment is November 10, 1997.

Rule No. 560-X-5-.03. Geriatric Inpatient Psychiatric Benefits

1. For purposes of this chapter, an inpatient is a person, age 65 or over, who has been admitted to a free-standing psychiatric facility specializing in the diagnosis, treatment and care of geriatric patients occupying beds, for the purpose of maintaining or restoring to the greatest possible degree of health and independent functioning.

2. The number of days of care charged to a recipient of inpatient psychiatric service is always units of full days. A day begins at midnight and ends 24 hours later. The midnight to midnight method is used in reporting days of care for the recipient, even if the facility uses a different definition of day for statistical or other purposes.

3. Medicaid reimbursement is available for the day of admission, but not the day of discharge.

4. Therapeutic visits away from the psychiatric facility to home, relatives or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient.

   a. Therapeutic visits may be authorized up to 14 days per admission if certified by the attending physician as medically necessary in the treatment of the recipient. No part of the time spent on any therapeutic leave may be billed to Medicaid.

   b. Return to inpatient status from therapeutic visits exceeding 14 days per admission will be considered a readmission with the required certification of need for treatment documented in the patient's record.

   c. Therapeutic visit records will be reviewed retrospectively by the Quality Assurance Program at Medicaid. Providers that have received payments for therapeutic visits will have funds recouped.

Authority: State Plan, Attachment 3.1-A, 4.19-A. 42 C.F.R. Section 436.1004. Rule effective October 12, 1995. The effective date of this amendment is November 10, 1997.

Rule No. 560-X-5-.04. Certification of Need for Service

1. Certification of need for services is a determination which is made by a physician regarding the Medicaid recipient's treatment needs for admission to the facility.

2. The physician must certify for each applicant or recipient that inpatient services in a mental hospital are or were needed.

3. The certification must be made at the time of admission. No retroactive certifications will be accepted.

4. For individuals applying for Medicaid while in the hospital, the certification must be made before Medicaid can authorize payment.

5. The physician must complete the PSY-5 form, which is the certification of need for care. This form must be kept in the patient's record.

6. The PSY-6 form, or acceptable equivalent approved by Medicaid, which is the recertification of need for continued inpatient services for each applicant or recipient, must be completed by a physician, a physician assistant, or a nurse practitioner acting under the supervision of a physician.

7. The PSY-6 form, or acceptable equivalent must be completed at least every 60 days after initial certification. This form must be kept in the patient's record.

8. The physician must complete an assessment note in the patient's record within 24 hours of a patient's return from any leave status.

Authority: 42 C.F.R. Section 441, Subpart D. Rule effective October 12, 1995. The effective date of this amendment is November 10, 1997.

Rule No. 560-X-5-.05. Medical, Psychiatric, and Social Evaluation

1. Before admission to a psychiatric facility or before authorization for payment, the attending physician, psychiatrist, or staff physician must make a medical evaluation of each individual's need for care in the facility. Appropriate professional personnel must make a psychiatric and social evaluation.

2. Each medical evaluation must include:

    a. Diagnosis;

    b. Summary of present medical findings;

    c. Medical history;

    d. Mental and physical functional capacity;

    e. Prognosis; and

    f. A recommendation by the physician concerning:

        1. Admission to the psychiatric facility; or

        2. Continued care in the psychiatric facility for individuals who apply for Medicaid while in the facility.

Authority: 42 C.F.R. Section 456.170. Rule effective October 12, 1995.

Rule No. 560-X-5-.06. Plan of Care

1. The attending physician or staff physician must establish a written plan of care for each individual before admission to a mental hospital and before authorization of payment.

2. The plan of care must include:

    a. Diagnosis, symptoms or complaints indicating a need for admission to inpatient care;

    b. Description of the functional level of the patient;

    c. Treatment objectives;

    d. Orders for medications, treatments, therapies, activities, restorative/rehabilitative services, diet, social services and special procedures needed for health and safety of the patient; and

    e. Continuing care plans that include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family and community service providers upon discharge.

3. The plan of care must be reviewed at least every 90 days or with significant changes in patient functioning or acuity by the attending or staff physician and other appropriate staff involved in the care of the recipient.

4. The plan of care will be evaluated to ensure that the recipient is receiving treatment that maintains or will restore him to the greatest possible level of health and independent functioning.

5. A written report of the evaluations described in Rule No. 560-X-5-.05 and the plan of care described in this section must be in the individual's record at the time of admission or immediately upon completion of the report if the individual is already in the facility.

Authority: 42 C.F.R. Section 456.180. Rule effective October 12, 1995. The effective date of this amendment is November 10, 1997.

Rule No. 560-X-5-.07. Utilization Review (UR) Plan

As a condition of participation in the Title XIX Medicaid program, each psychiatric facility shall:

1. Have in effect a written UR Plan that provides for review of each recipient's need for services that the facility furnishes to him. This written UR Plan must meet the requirements under 42 C.F.R Section 456.201 through Section 456.245;

2. Maintain recipient information required for the UR Plan under 42 C.F.R. Section 456.211, which shall include the certification of need for service and the plan of care; and

3. Provide a copy of the UR Plan and any subsequent revisions to Medicaid for review and approval.

Authority: 42 C.F.R. Section 456.200 - 456.245. Rule effective October 12, 1995.

Rule No. 560-X-5-.08. Payment

1. Payment for inpatient services provided by psychiatric facilitates for individuals age 65 and older shall be the per diem rate established by Medicaid for the hospital, which is based on the Medicaid cost report and all the requirements expressed in Chapter 23 of the Alabama Medicaid Administrative Code. Patient liabilities, if applicable, will be deducted from the per diem. The hospital will be responsible for collecting the liability amount from the patient and/or his/her sponsor. Providers should reference their billing manual for claim submission procedures.

2. Providers are required to file a complete uniform Medicaid cost report for each fiscal year. Two copies of this report must be received by Medicaid within three months after the Medicaid cost report year-end.

3. If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of $100.00 per day for each calendar day after the due date.

4. Hospitals that terminate participation in the Medicaid program must provide a final cost report within 120 days of the date of termination of participation.

Authority: State Plan, Attachment 4.19-A. 42 C.F.R. Section 447, Subpart D. Rule effective October 12, 1995. The effective date of this amendment is November 10, 1997.

Rule No. 560-X-5-.09. Inspection of Care

1. The Medicaid Quality Assurance Program will periodically perform an inspection of care and services provided to recipients in accordance with 42 C.F.R. Part 456, Subpart I. The review team must consist of psychiatrist or physician with knowledge and experience in the provision of care in mental institutions and other appropriate mental health and social service personnel. This physician may not inspect the care of a recipient for whom he is the attending physician or for whom he has served as the consulting physician. The Medicaid Agency will determine, based on the quality of care and services provided in the facility and the condition of recipients in the facility, at what intervals inspections will be made. However, the review team must inspect the care and services provided to each recipient in the facility at least annually. The inspection must include:

    a. Personal contact with and observations of each recipient; and/or

    b. Review of each recipient's medical record.

2. In making determination of adequacy of services, the team may consider items such as, but not limited to:

    a. The medical, social, and psychiatric evaluations and an assessment of the adequacy and completeness of the plan of care;

    b. The plan of care is followed;

    c. All services ordered are provided and properly documented;

    d. The attending physician reviews of prescribed medication regimens are made at the appropriate times and properly documented;

    e. Tests or observations of each recipient indicated by his medication regimen are made at appropriate times and properly documented;

    f. Professional progress notes are made as required and consistent with the observed condition of the recipient;

    g. The recipient receives adequate services based on observation;

h. The recipient needs continued inpatient care; and

i. Alternative care is available and appropriate.

3. Each recipient's chart will be reviewed by the Medicaid review team to assure that the following items are included on the chart:

   a. Certification of need. (PSY-5)

   b. Recertifications. (PSY-6 or acceptable equivalent)

   c. Completed medical, social, and psychiatric evaluations.

   d. Current plan of care.

4. The review team will also review the chart for:

   a. Physician, nurse, and other professional staff members' progress notes. These notes will be assessed for consistency with the observed condition of the patient.

   b. Services being provided as ordered.

   c. Completeness of the plan of care.

   d. Documentation supporting the need for continued hospitalization.

   e. Documentation of review of medication by a physician every 30 days.

   f. Discharge plan or a plan for alternative care.

5. The review team must submit a report on each inspection that contains observations, conclusions, and recommendations as specified in 42 C.F.R Section 456.611.

6. At the time of the inspection, the team will also review each recipient's record for compliance with all state and federal regulations. Payments for admissions that are found to be out of compliance may be recouped by Medicaid.

Authority: 42 C.F.R, Part 456, Subpart I; Section 456.600 - 456.614. Rule effective October 12, 1995. The effective date of this amendment is November 10, 1997.

Rule No. 560-X-5-.10. Authorization for Admission

1. All admissions to psychiatric hospitals for recipients age 65 or older must be approved by Medicaid prior to payment authorization.

2. A Medicaid psychiatric utilization reviewer shall be responsible for taking all telephone reviews. Medical records and/or other documentation may be requested when the medical necessity of the admission cannot be determined by telephone review. Providers will receive written notification when admissions and/or recertifications are not found to be medically necessary.

3. Reviews shall be called in within eight working days after admission. Reviews that are not called in within eight working days will be approved beginning the day the review is called in, provided the criteria for admission and continued stay are met.

4. Information required for admission review must include, but is not limited to:

   a. Recipient information:

      1. admitting diagnosis;

      2. events leading to hospitalization;

3. history of psychiatric treatment;
4. current medications;
5. physician orders;
6. presenting signs and symptoms.

b. Verification that Certification of Need Form (PSY-5) has been completed.

c. Verification that medical, social, and psychiatric evaluations have been completed.

d. Verification that initial treatment plan (Plan of Care) is present on recipient's chart.

5. Medicaid's Psychiatric Criteria for Age 65 or Over will be utilized in determining if the admission is approved or denied.

6. If the admission is approved, the facility will be given verbal authorization to bill for the stay and the initial continued stay review (CSR) date will be assigned.

7. If the admission cannot be approved, based on the information received by the review unit, additional information will be requested.

8. If a determination is made by Medicaid that the admission is not medically necessary, the facility will be notified in writing within two working days after a determination has been made.

Authority: 42 C.F.R. Section 456.171. Rule effective October 12, 1995. The effective date of this amendment is November 10, 1997.

Rule No. 560-X-5-.11. Continued Stay Reviews

1. The hospital's utilization review personnel will be responsible for performing continued stay reviews on recipients who require continued inpatient hospitalization.

2. The initial continued stay review should be performed on the date assigned by Medicaid. Subsequent reviews should be performed at least every 90 days from the initial CSR date assigned, provided the patient is approved for continued stay. Each continued stay review date assigned should be recorded in the patient's record.

3. If the facility's utilization review personnel determines the patient does not meet the criteria for continued stay, the case should be referred to the facility's psychiatric advisor. If the advisor finds that the continued stay is not needed, the hospital's utilization review procedure for denial of a continued stay should be followed.

4. If a final decision of denial is made, the hospital must notify the recipient and the attending physician within two days of the adverse determination. Medicaid should be notified in writing within 10 days after the denial is made.

5. The facility's utilization review personnel shall be responsible for phoning Medicaid with a report whenever patients are placed on leave status or return from leave. A brief summary describing the outcome of the therapeutic leave should be addressed at this time for patients returning from any leave status.

Authority: 42 C.F.R. Section 441.102. 42 C.F.R Section 456.231 through 42C.F.R Section 456.238. Rule effective October 12, 1995. Effective date of this amendment is November 10, 1997.

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Chapter 6. Physicians.

Rule No. 560-X-6-.01. Physician Program - General.

(1) The term "physician" shall mean (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the doctor performs such functions; (2) a doctor of dentistry or of dental or oral surgery who is licensed to practice in the state in which the service is rendered, and legally authorized to perform such function but only with respect to: surgery related to the jaw, the reduction of any fracture related to the jaw or facial bones, or surgery within the oral cavity for removal of lesions or the correction of congenital defects.

(2) Participation. Providers who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. An enrollment application may be requested from EDS Provider Enrollment, 301 Technacenter Drive, Montgomery, AL 36117, or downloaded from the Medicaid website at www.medicaid.state.al.us. Completed enrollment applications should be returned to EDS Provider Enrollment.

Physicians having limited licenses will not be enrolled by the Medicaid fiscal agent unless complete information as to the limitations and reasons is submitted in writing to the Provider Enrollment Unit for review and consideration for enrollment.

(3) Nonphysician Practitioner Services--Medicaid payment may be made for the professional services of the following physician-employed practitioners:

physician assistants (PAs)
certified registered nurse practitioners (CRNPs)

(a) PAs and CRNPs: The Alabama Medicaid Agency will make payment for services of certified physician assistants (PAs) and certified registered nurse practitioners (CRNPs) who are legally authorized to furnish services and who render the services under the supervision of an employing physician with payment made to the employing physician. Medicaid will not make payment to the PA or CRNP.

1. The employing-physician must be an Alabama Medicaid provider in active status.
2. The PA or CRNP must enroll with the Alabama Medicaid Agency and receive an Alabama Medicaid provider number with the employing-physician as the payee.
3. Covered services furnished by the PA or CRNP must be billed under the PAs or CRNPs name and Alabama Medicaid provider number.
4. The covered services for PAs and CRNPs are limited to the codes listed in the Alabama Medicaid Billing Manual in Appendix O. Other PA or CRNP approved services include all injectable drugs, all laboratory services in which the laboratory is CLIA certified to perform, and select CPT codes authorized for independent CRNPs and are listed in Appendixes H and O of the Alabama Medicaid Billing Manual.
5. The office visits performed by the PA or CRNP will count against the recipient's yearly benefit limitation.

6. The PA or CRNP must send a copy of the prescriptive authority granted by the licensing board for prescriptions to be filled. This information must be sent to:

EDS Provider Enrollment
301 Technacenter Drive
Montgomery, AL 36117

7. The PA or CRNP cannot make physician-required visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits.

8. The employing-physician need not be physically present with the PA or CRNP when the services are being furnished to the recipient; however, he/she must be immediately available to the PA or CRNP for direct communication by radio, telephone, or telecommunication.

9. The PA or CRNP employing physician is responsible for the PA's or CRNP's professional activities and for assuring that the services provided are medically necessary and appropriate for the patient.

10. There shall be no independent, unsupervised practice by PAs or CRNPs.

(4) Physicians are expected to render medically necessary services to Medicaid patients in the same manner and under the same standards as for their private patients, and bill the Alabama Medicaid Agency their usual and customary fee.

(5) Payments from Medicaid funds can be made only to physicians who provide the services; therefore, no reimbursement can be made to patients who may personally pay for the service rendered.

(6) Refer to Chapter 20 concerning third-party insurance carriers.

(7) The physician agrees when billing Medicaid for a service that the physician will accept as payment in full, the amount paid by Medicaid for that service, plus any cost-sharing amount to be paid by the recipient, and that no additional charge will be made. The physician shall not charge or bill the recipient for cancelled or missed appointments. Conditional collections from patients, made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible. The physician may bill the patient, in addition to the cost-sharing fee, for services rendered in the following circumstances:

(a) When benefits are exhausted for the year,
(b) When the service is a Medicaid non-covered benefit.

(8) A hospital-based physician who is a physician employed by and paid by a hospital may not bill Medicaid for services performed therein and for which the hospital is reimbursed. A hospital-based physician shall bill the Medicaid Program on a HCFA-1500, Health Insurance Claim Form or assign their billing rights to the hospital, which shall bill the Medicaid Program on a HCFA-1500 form. A hospital-based physician who is not a physician

employed by and paid by a hospital shall bill Medicaid using a HCFA-1500 Health Insurance Claim Form.

(9) A physician enrolled in and providing services through a residency training program shall not bill Medicaid for services performed. For tracking purposes only, these physicians will be assigned pseudo Medicaid license numbers. Pseudo license numbers must be used on prescriptions written for Medicaid recipients.

(10) Supervising physicians may bill for services rendered to Medicaid recipients by residents enrolled in and providing services through a residency training program. The following rules shall apply to physicians supervising residents:

(a) The supervising physician shall sign and date the admission history and physical and progress notes written by the resident.

(b) The supervising physician shall review all treatment plans and medication orders written by the resident.

(c) The supervising physician shall be available by phone or pager.

(d) The supervising physician shall designate another physician to supervise the resident in his/her absence.

(e) The supervising physician shall not delegate a task to the resident when regulations specify that the physician perform it personally or when such delegation is prohibited by state law or the facility's policy.

(11) Off Site Mobile Physician's Services shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, and Code of Federal Regulations including but not limited to the following requirements:

(a) Shall provide ongoing, follow-up, and treatment and/or care for identified conditions,

(b) Shall provide ongoing access to care and services through the maintenance of a geographically accessible office with regular operating business hours within the practicing county or within 15 miles of the county in which the service was rendered,

(c) Shall provide continuity and coordination of care for Medicaid recipients through reporting and communication with the Primary Medical Provider,

(d) Shall maintain a collaborative effort between the off-site mobile physician and local physicians and community resources. A matrix of responsibility shall be developed between the parties and available upon enrollment as an off-site mobile physician,

(e) Shall provide for attainable provider and recipient medical record retrieval,

(f) Shall maintain written agreements for referrals, coordinate needed services, obtain prior authorizations and necessary written referrals for services prescribed. All medical conditions identified shall be referred and coordinated, for example:

1. Eyeglasses,
2. Comprehensive Audiological services,
3. Comprehensive Ophthalmological services,
4. Patient 1st and EPSDT Referrals,

(g) Shall not bill Medicaid for services which are free to anyone. Provider shall utilize a Medicaid approved sliding fee scale based on Federal Poverty Guidelines,

(h) Shall ensure that medical record documentation supports the billing of Medicaid services, and

(i) Shall obtain signed and informed consent prior to treatment.

(12) (a) Effective April 1, 2008, all prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads. The term "written prescription" does not include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy, or prescriptions communicated to the pharmacy by telephone by a prescriber. This requirement does not apply to refills of written prescriptions which were executed before April 1, 2008. It also does not apply to drugs provided in nursing facilities, intermediate care facilities for the mentally retarded, and other institutional and clinical settings to the extent the drugs are reimbursed as part of a per diem amount, or where the order for a drug is written into the medical record and the order is given directly to the pharmacy by the facility medical staff.

(b) To be considered tamper-resistant on or after April 1, 2008, a prescription pad must contain at least one of the following three characteristics:

1. one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; or

2. one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or

3. one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

(c) To be considered tamper-resistant on or after October 1, 2008, a prescription pad must contain all of the foregoing three characteristics.

Author: Mary Timmerman, Associate Director, Medical Services Program.
Statutory Authority: State Plan Attachment 3.1-A and 4.19-B(4); Title XIX, Social Security Act; 42 USC 1320a-7b (Sec. 1128B of the SSA), P.L. 110-28 (SSA Sec. 1903(i)); 42 CFR, Sections 447.15, 405.522, .523, 401, 441.56, et seq.; and Alabama Code Section 34-24-75(d)(1975).
History: Rule effective October 1, 1982. Amended April 15, 1983, March 12, 1984, May 9, 1984, June 9, 1985, March 12, 1987; March 15, 1994; January 12, 1995; April 1, 1998; March 20, 2000; and June 12, 2000. **Amended**: Filed December 18, 2000; effective March 12, 2001. **Amended**: Filed March 20, 2002; effective June 14, 2002. **Amended**: Filed February 18, 2003; effective May 16, 2003. **Amended**: Filed December 17, 2004, effective March 17, 2005. **Amended**: Filed June 20, 2006; effective September 15, 2006. **Amended:** Emergency Rule filed and effective April 1, 2008. **Amended:** Filed April 21, 2008, effective July 16, 2008.

Rule No. 560-X-6-.02. Submission of Claims - General

(1) Claims should be submitted on HCFA-1500 (Health Insurance Claim) forms. Each claim filed by a physician constitutes a contract with Medicaid.

(2) For claim filing limitations, refer to Chapter 1, Rule 560-X-1-.17.

(3) Physicians who want to participate in the Alabama Medicaid Program must be enrolled and receive a provider number.

(4) Claims must include the name and Medicaid provider number of the physician who takes responsibility for the services. The provider number must identify the responsible individual, not a group or institution. Reimbursement may be made to a physician submitting a claim for services furnished by another physician in the event there is a reciprocal arrangement as long as the claim identifies the physician who actually furnished the service. The substitute physician should be enrolled with Medicaid as an active provider. The reciprocal arrangement may not exceed 14 continuous days in the case of an informal arrangement or 90 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Payment may not be made for services provided by providers who have been suspended or terminated from participation in the Medicaid program. See Rule No. 560-X-4-.04 for details.

(5) Incomplete or inaccurate claim forms submitted for processing will be returned to the provider by the Medicaid fiscal agent for the necessary information.

(6) Before submitting a claim, a careful check should be made to see that the Medicaid identification number agrees with the number and exact spelling of the name on the patient's plastic Medicaid eligibility card.

(7) In filling out claim forms, providers must use diagnosis codes from the ICD-9-CM Code Book and procedure codes from the CPT Code Book, or approved procedures codes designated by Medicaid.

(8) Factoring arrangements in connection with the payment of claims under Medicaid are prohibited.

(9) Medicaid's fiscal agent will furnish to new providers a manual containing billing instructions.

(10) Pharmacists must have the physician's license number prior to billing for prescriptions. Refer to Chapter 16.

(11) Fragmentation of procedures, including laboratory procedures, under the Medicaid program is prohibited.

Author: Mary Timmerman, Associate Director, Medical Services Program.

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R., Section 401, Et seq.; State Plan and Omnibus Budget Reconciliation Act of 1990 (Public Law 105-508).
History: Rule effective October 1, 1982. Amended March 12, 1984, November 11, 1985, and March 12, 1987. Emergency rule effective April 1, 1991. Amended July 13, 1991, October 13, 1992, and March 15, 1994. Amended: Filed March 20, 2002; effective June 14, 2002.

Rule No. 560-X-6-.03. Submission of Claims by Hospital-Based Physicians.

Hospital-based physicians will be reimbursed under the same general system as is used in Medicare. Bills for services rendered will be submitted as follows:

(1) All hospital-based physicians, including emergency room physicians, radiologists, and pathologists, shall bill the Medicaid program on a HCFA-1500, Health Insurance Claim form or assign their billing rights to the hospital, which shall bill the Medicaid program on a HCFA-1500 (Health Insurance Claim) form.

(a) Physician services personally rendered for individual patients will be paid only on a reasonable charge basis (i.e., claims submitted under an individual provider number on a physician claim form). This includes services provided by a radiologist and/or pathologist.

(b) Reasonable charge services are: 1) personally furnished for a patient by a physician; 2) ordinarily require performance by a physician and; 3) contribute to the diagnosis or treatment of an individual patient.

(2) Services of hospital-based physicians that do not meet the criteria of reasonable charge as define above, but benefit a hospital or its patient are reimbursable only on a reasonable cost basis through the hospital cost report. Please refer to Laboratory, Radiology, and Hospital Chapters of this code for further details.

Authority: Title XIX, Social Security Act; 42 C.F.R., Section 405.401, Et seq.; and State Plan. Rule effective October 1, 1982. Emergency Rule effective October 1, 1984. Amended January 8, 1985 and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.04. Submission of Claims: Routing of Claims.

(1) MEDICAID ELIGIBLES.

(a) Claims should be submitted to the fiscal agent in accordance with instructions for these patients who are enrolled for MEDICAID ONLY.

(b) Reimbursement for physicians' services will NOT be made to the patient, sponsor, or nursing facility. The Medicaid program does not provide for reimbursement of this expense to these individuals or facilities.

(2) MEDICARE ELIGIBLES.

(a) For Medicaid patients who are also enrolled for benefits under Part B refer to Chapter 1, this Code and the Alabama Medicaid Provider Manual.

Authority: Title XIX, Social Security Act; 42 CFR, Section 401, Et seq.; and State Plan. Rule effective October 1, 1982. Amended May 9, 1984, and March 12, 1987. Emergency rule effective February 1, 1989. Amended May 12, 1989. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.05. Submission of Claims: Out-of-State Claims DO NOT Need Prior Approval.

Except for those services which require prior approval as stated in Chapters 1 and 6 of this Administrative Code (i.e. transplants and select surgeries), medical care outside the State of Alabama does not require prior authorization by the Alabama Medicaid Agency.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended October 9, 1984; March 12, 1987 and October 13, 1992. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.06. Medicaid Provider Payments.

Payment from Medicaid funds can be made to the actual provider of service only. The only exceptions to this rule are payments made within the same group, or for substitute physicians.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective March 15, 1994.

Rule No. 560-X-6-.07. Enrollment of Out-of-State Providers.

An out-of-state physician who wishes to participate in the Alabama Medicaid Program must enroll with the Alabama Medicaid Program and be assigned a provider identification number. To do so, the physician should send a written request to Medicaid's fiscal agent, Provider Enrollment Division. The following information must be included in the enrollment application:

1. Name;
2. Address of Place of Business;
3. Provider Type and specialty;
4. Social Security Number;
5. Federal Employer Identification Number;
6. Medicaid License Number;
7. Personal Historical Data; and
8. Original Provider Signature.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended May 9, 1984, March 12, 1987 and March 15, 1994. Effective date of this amendment January 12, 1995.

Rule No. 560-X-6-.08. Consent Statements Required Before Services Are Provided.

Refer to the rules regarding consent and authorization contained in paragraphs within this chapter regarding sterilization, and abortions, Chapter 14 of this Code, and to Title 22, Chapter 8, Code of Alabama, 1975. NOTE: Non-therapeutic sterilization performed for the sole purpose of rendering a person permanently incapable of reproducing is not available to persons under twenty-one (21) years of age under the Medicaid Program.

Arthur: Mary Timmerman, Associate Director, Medical Services Program
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 441.257; Section 401, Et seq.; State Plan.
History: Rule effective October 1, 1982 and March 12, 1987. Amended March 15, 1994. Amended: Filed March 20, 2002; effective June 14, 2002.

Rule No. 560-X-6-.09. Consent Forms Required Before Payments Can Be Made.

(1) Abortions: A claim seeking payment for an abortion must be accompanied by one or more (depending on the circumstance) of the forms required by federal law and a copy of the medical records. Payment is available for abortions as provided under federal law.

In the event the abortion does not meet the requirements of federal law, and the recipient elects to have the abortion, the provider may bill the recipient for the abortion.

(2) Sterilization: A claim seeking payment for sterilization must be accompanied by a sterilization form (Form 193) or Medicaid approved substitute.

Sterilization by Hysterectomy

(a) Payment is not available for a hysterectomy if:

1. It was performed solely for the purpose of rendering an individual permanently incapable of reproducing, or

2. If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are no longer covered under Medicaid. Hysterectomies done as a medical necessity as treatment of disease can be paid for by the Medicaid funds under the physician's program.

(b) A claim seeking payment for a hysterectomy performed for reasons of medical necessity, and not for purpose of sterilization, must be accompanied by a Hysterectomy Consent

Form PHY-81243 (rev. 052082) or Medicaid approved substitute. See Chapter 28 for sample copy of this form. The doctor's explanation to the patient that the operation will make her sterile, and the doctor's and recipient's signature must precede the operation except in the case of medical emergency.

The consent form is not required if the operation took place on or after March 8, 1979, and if (1) the physician who performed the hysterectomy certifies in writing that the patient was already sterile when the hysterectomy was performed; the cause of sterility must be stated in this written statement, or if (2) the physician who performed the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgement was not possible. This written statement must include a description of the nature of the emergency, or if (3) the hysterectomy was performed during a period of retroactive Medicaid eligibility, and the physician who performed the hysterectomy submits, in lieu of the consent form, a written statement certifying that the individual was informed before the operation that the hysterectomy would make her sterile.

Completed copies of the consent form must be submitted by a provider-physician, hospital, laboratory, or other providers who submit a claim related to a hysterectomy. The form must be signed by both the patient, or a representative, and the physician.

Copies of the signed form should be obtained from the physician by the hospital, laboratory, or other provider and submitted with their claims.

(3) Accident: A claim seeking payment for service made necessary because of an accident may require an accident/insurance form (XIX-TPD-1-76). See Chapter 20 (Third Party) for specific details. A copy of this form is included in Chapter 28.

Author: Brenda Vaughn, Program Manager, Medical Services Program.
Statutory Authority: Title XIX, Social Security Act, 42 C.F.R. Section 401, Et seq.; State Plan.
History: Rule effective October 1, 1982. Amended March 12, 1987. Emergency rule effective March 1, 1989. Amended June 16, 1989, and March 15, 1994. **Amended**: Filed March 20, 2002; effective June 14, 2002. **Amended**: Filed February 18, 2003; effective May 16, 2003.

Rule No. 560-X-6-.10. Physician's Role in Certification and Recertification.

(1) For information about hospital certification and recertification see Rule No. 560-X-7-.16.

(2) In a skilled or intermediate nursing care facility, in the hospital and for the Home Health Care Program, Medicaid patients must be recertified by a physician at least every sixty (60) days. The certification form will be made a permanent part of the patient's record.

Authority: Title XIX, Social Security Act, 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended July 8, 1983 and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.11. Physician's Role in Extension of Hospital Days.

(1) With the exception of Medicaid recipients eligible for treatment under the EPSDT (MediKids) program, additional hospital days are not covered. Refer to Chapter 7, Hospital Program and Chapter 11, EPSDT, for specifics.

Authority: Title XIX, Social Security Act, 42 C.F.R. Section 401, Et seq.; State Plan. Rule effective October 1, 1982. Amended July 8, 1983 and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.12. Covered Services: General.

(1) In general, physician services are covered by Medicaid if the services are:

(a) Considered medically necessary by the attending physician. However, when the persons designated responsible for utilization review have issued a denial for inpatient days, no ancillary charge or professional charges will be reimbursed during the denied period.

(b) Designated by procedure codes in Physicians' Current Procedural Terminology, or designated by special procedure codes created by Medicaid for its own use.

(2) Physicians will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories. Physicians may submit claims for laboratory work done by them in their own offices or own laboratory facilities. For specific information concerning the "professional component" and drawing and extraction reimbursement, see the laboratory chapter.

(3) If a physician is not sure whether a service is covered, that physician can phone or write Medicaid. Such inquiries should be made to:

Associate Director, Medical Services; Physicians Program
Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
Montgomery, Alabama 36103-5624
Telephone: (334) 242-5000

Author: Mary Timmerman, Associate Director, Medical Services Program
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R, Section 401, Et seq.; State Plan.
History: Rule effective October 1, 1982. Amended June 5, 1983, May 9, 1984, May 8, 1985, March 12, 1987, March 15, 1994, and January 12, 1995. Amended: Filed March 20, 2002; effective June 14, 2002.

Rule No. 560-X-6-.13. Covered Services: Details on Selected Services.

(1) Acupuncture: Not covered.

(2) Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure which is a covered service under the Alabama Medicaid Program. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered. For billing purposes, anesthesia services rendered with medical direction for one CRNA or AA is considered a service performed by the anesthesiologist. In order to bill for medical supervision, the anesthesiologist must be physically present and available within the operating suite. "Physically present and available" means the anesthesiologist would not be available to render direct anesthesia services to other patients. However, addressing an emergency of short duration or rendering the requisite CRNA or AA supervision activities (listed below in a. through g.) within the immediate operating suite is acceptable as long as it does not substantially diminish the scope of the supervising anesthesiologist's control. If a situation occurs which necessitates the anesthesiologist's personal continuing involvement in a particular case, medical supervision ceases to be available in all other cases. In order for the anesthesiologist to be reimbursed for medical supervision activities of the CRNA or AA , the anesthesiologist must document the performance of the following activities:

(a) performs a pre-anesthesia examination and evaluation;
(b) prescribes the anesthesia plan;
(c) personally participates in the most demanding procedures in the anesthesia plan, including induction as needed, and emergencies;
(d) ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
(e) monitors the course of anesthesia administration at frequent intervals;
(f) remains physically present and available for immediate diagnosis and treatment of emergencies; and
(g) provides indicated post-anesthesia care.

Administration of anesthesia by a self-employed Certified Registered Nurse Anesthetist (CRNA) is a covered service when the CRNA has met the qualifications and standards set forth in Rule No. 610-X-9-.01 through 610-X-9-.04 of the Alabama Board of Nursing Administrative Code. The CRNA must enroll and receive a provider number to bill under the Alabama Medicaid Program. When billing for anesthesia services, providers shall follow the guidelines set forth in the current Relative Value Guide published by the American Society of Anesthesiologists for basic value and time units. No Physical Status Modifiers can be billed.

Administration of anesthesia by a qualified Anesthesiology Assistant (AA) is a covered service when the AA has met the qualifications and standards set forth in Rule 540-X-7-.51 of the Alabama Board of Medical Examiners Administrative Code. Reimbursement shall be made only when the AA performs the administration of anesthesia under the direct medical supervision of the anesthesiologist.

Anesthesia services may include, but are not limited to, general anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive treatment administered to maintain optimal anesthesia care deemed necessary by the anesthesiologist during the procedure. Anesthesia services include all customary preoperative and postoperative visits, the anesthesia care during the procedure, the administration of any fluids deemed necessary by the attending physician, and any usual monitoring procedures. Therefore, additional claims for such services should not be submitted.

(h) Local anesthesia is usually administered by the attending surgeon and is considered to be part of the surgical procedure being performed. Thus, additional claims for local anesthesia by the surgeon should not be filed. Any local anesthesia administered by an attending obstetrician during delivery (i.e. pudendal block or paracervical block) is considered part of the obstetrical coverage. Thus, additional claims for local anesthesia administered by an attending obstetrician during delivery should not be filed.

(i) When regional anesthesia (i.e., nerve block) is administered by the attending physician during a procedure, the physician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service when performed by an anesthesiologist. When regional anesthesia is administered by the attending obstetrician during delivery (i.e., saddle block or continuous caudal), the obstetrician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service performed by an anesthesiologist. When regional anesthesia is administered by an anesthesiologist during delivery or other procedure, the anesthesiologist's fee will be covered and should be billed separately.

(j) When a medical procedure is a noncovered service under the Alabama Medicaid Program, the anesthesia for that procedure is also considered to be a noncovered service.

(3) Artificial Eyes: Must be prescribed by a physician.

(4) Autopsies: Not covered.

(5) Biofeedback: Not covered.

(6) Blood Tests: Not covered for marriage licenses.

(7) CAT Scans: Computerized Axial Tomograph (CAT) Scans are covered as medically necessary.

(8) Chiropractors: Not covered, except for QMB recipients and for services referred directly as a result of an EPSDT screening.

(9) Chromosomal Studies: Chromosomal studies (amniocentesis) on unborn children being considered for adoption are not covered. Medicaid can pay for these studies in the case of prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.

(10) Circumcision: Circumcision of newborns is a covered service. If medically necessary, non-newborn circumcision is covered.

(11) Diet Instruction: Diet instruction performed by a physician is considered part of a routine visit.

(12) Drugs:

(a) Non-injectable drugs: See Chapter 16 of this Code.

(b) Injectable drugs: Physicians who administer injectable drugs to their patients may bill Medicaid for the cost of the drug by using the procedure code designated by Medicaid for this purpose. The injectable administration code may be used only when an office visit or nursing home visit is not billed.

(13) Examinations: Office visits for examinations are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this limit.

(a) Annual routine physical examinations are not covered.

(b) Medical examinations for such reasons as insurance policy qualifications are not covered.

(c) Physical examinations for establishment of total and permanent disability status if considered medically necessary are covered.

(d) Medicaid requires a physician's visit once each 60 days for patients in a nursing home. Patients in intermediate care facilities for the mentally retarded will receive a complete physical examination at least annually.

(e) Physical examination, including x-ray and laboratory work, will be payable for recipients eligible through the EPSDT Program if the physician has signed an agreement with Medicaid to participate in the screening program.

(14) Experimental Treatment and/or Surgery: Not covered.

(15) Eyecare:

(a) Eye examinations by physicians are a Medicaid covered service.

(b) Office visits for eyecare disease are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(16) Filing Fees: Not covered.

(17) Foot Devices: See Chapter 13 (Supplies, Appliances, and Durable Equipment) for specific details.

(18) Hearing Aids: See Hearing Aids Chapter in this Code.

(19) Hypnosis: Not covered.

(20) Immunizations: Payment for immunizations against communicable diseases will be made if the physician normally charges his patients for this service.

(a) The Department of Public Health provides vaccines at no charge to Medicaid physicians enrolled in the Vaccines For Children (VFC) Program and as recommended by the Advisory Committee on Immunization.

(b) Effective October 1, 1994, the Alabama Medicaid Agency will begin reimbursement of administration fees for vaccines provided free of charge through the Vaccines For Children (VFC) Program.

(c) Medicaid tracks usage of the vaccine through billing of the administration fee using the appropriate CPT-4 codes.

(d) The Omnibus Budget Reconciliation Act of 1993 mandated that Medicaid can no longer cover a single antigen vaccine if a combined antigen vaccine is medically appropriate. This change will become effective January 1, 1994. The single antigen vaccines may still be billed only if prior approved before given and a medical justification is given. These vaccines are diphtheria, measles, mumps, and rubella. In order to request the prior approval for these vaccines, providers should contact the EDS, Prior Authorization Unit at P.O. Box 244036, Montgomery, AL 36124-4036.

(21) Infant Resuscitation: Newborn resuscitation (procedure code 99440) is a covered service when the baby's condition is life threatening and immediate resuscitation is necessary to restore and maintain life functions. Intubation, endotracheal, emergency procedure (procedure code 31500) cannot be billed in conjunction with newborn resuscitation.

(22) Intestinal Bypass: Not covered for obesity.

(23) Laetrile Therapy: Not covered.

(24) Newborn Claims: The five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital that may be filed under the mother's name and number or the baby's name and number are routine newborn care and discharge codes, circumcision, newborn resuscitation, standby services following a caesarean section or a high-risk vaginal delivery, and attendance at delivery (when requested by delivering physician) and initial stabilization of newborn. Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or OB/GYN is on standby in the operating or delivery room during a cesarean section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report. When filing claims for these five kinds of care, CPT codes shall be utilized. All other newborn care (any care other than routine newborn care for a well-baby), before and after the mother leaves the hospital, must be billed under the child's name and number.

(25) Obstetrical Services and Related Services: Office visits for obstetrical care are counted as part of each recipient's annual office visit limit under certain conditions. See Rule No. 560-X-6-.14 for details about this quota.

(a) Family Planning: See the Family Planning Chapter in this Code.

(b) Abortions: See Rule No. 560-X-6-.09 (1).

(c) Hysterectomy: See Rule No. 560-X-6-.09, paragraph 3.

(d) Maternity Care and Delivery: The services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a physician provides total obstetrical care, the procedure code which shall be filed on the claim form is the code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery. If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time she is eligible will be covered. When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician shall use a "global" obstetrical code in billing. If a physician submits a "global" fee for maternity care and delivery, the visits covered by these codes are not counted against the recipient's limit of annual office visits. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

1. Antepartum care includes all usual prenatal services such as initial office visit at which time pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling, etc.; therefore, additional claims for routine services should not be filed. Antepartum care also includes routine lab work (e.g., hemoglobin, hematocrit, chemical urinalysis, etc.); therefore, additional claims for routine lab work should not be filed.

(i) To justify billing for global antepartum care services, physicians must utilize the CPT-4 antepartum care global codes (either 4-6 visits, or 7 or more visits), as appropriate. Claims for antepartum care filed in this manner do not count against the recipient's annual office visit limit. Physicians who provide less than four (4) visits for antepartum care must utilize CPT-4 codes under office medical services when billing for these services. These office visit codes will be counted against the recipient's annual office visit limit.

(ii) Billing for antepartum care services in addition to "global" care is not permissible; however, in cases of pregnancy complicated by toxemia, cardiac problems, diabetes, neurological problems or other conditions requiring additional or unusual services or hospitalization, claims for additional services may be filed. If the physician bills fragmented services in any case other than high-risk or complicated pregnancy and then bills a "global" code, the fragmented codes shall be recouped. Claims for such services involved in complicated or high risk pregnancies may be filed utilizing CPT codes for Office Medical Services. Claims for services involving complicated or high risk pregnancies must indicate a diagnosis other than normal pregnancy and must be for services provided outside of scheduled antepartum visits. These claims for services shall be applied against the recipient's annual office visit limit.

2. Delivery and postpartum care: Delivery shall include vaginal delivery (with or without episiotomy) or cesarean section delivery and all in-hospital postpartum care. More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery or a claim for "global" care.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

3. Postpartum care includes office visits following vaginal or cesarean section delivery for routine postpartum care within sixty-two (62) days post delivery. Additional claims for routine visits during this time should not be filed.

4. Delivery only: If the physician performs the delivery only, he must utilize the appropriate CPT-4 delivery only code (vaginal delivery only or C-section delivery only). More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of the delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery only.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

5. Obstetrical ultrasounds are limited to two per pregnancy. Generally, first ultrasounds are conducted to detect gestational age, multiple pregnancies, and major malformations. Second ultrasounds may be conducted to detect fetal growth disorders (intrauterine growth retardation, macrosomia) and anomalies that would appear later or may have been unrecognizable in the earlier scan.

Additional ultrasounds may be prior approved by the Alabama Medicaid Agency if a patient's documented medical condition meets any of the following criteria:

(i) Gestational diabetes with complications (Type 1 diabetes, vascular disease, hypertension, elevated alpha-fetoprotein values, poor patent compliance);
(ii) Failure to gain weight, evaluation of fetal growth;
(iii) Pregnancy-induced hypertension;
(iv) Vaginal bleeding of undetermined etiology;
(v) Coexisting adnexal mass;
(vi) Abnormal amniotic fluid volume (polyhydramnios, oligohydramnios);
(vii) Pregnant trauma patient;
(viii) Congenital diaphragmatic hernia (CDH);
(ix) Monitoring for special tests such as fetoscopy, amniocentesis, or cervical cerclage placement;
(x) Assist in operations performed on the fetus in the uterus;
(xi) Detection of fetal abnormalities with other indicators or risk factors (Low human chorionic gonadotrophin (HCG) and high unconjugated oestriol (uE3) are predictive of an increased risk for Trisomy 18. Echogenic bowel grades 2 and 3 are indicative of an increased risk of cystic fibrosis and Trisomy 21);
(xii) Determination of fetal presentation;
(xiii) Suspected multiple gestation, serial evaluation of fetal growth in multiple gestation;
(xiv) Suspected hydatidiform mole;
(xv) Suspected fetal death;
(xvi) Suspected uterine abnormality;
(xvii) Suspected abruptio placenta;

(xviii) Follow-up evaluation of placental location for identified placenta previa.

Fee-for-service providers should submit requests for additional obstetrical ultrasounds to:

Prior Authorization Program
Alabama Medicaid Agency
P. O. Box 5624
Montgomery, AL 36103-5624

Maternity Waiver subcontractors should contact their Primary Provider for information regarding obstetrical ultrasounds.

(e) Sterilization: See the Family Planning Chapter in this Code.

(26) Medical Materials and Supplies: Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.

(27) Oxygen and Compressed Gas: A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to the Alabama Medicaid Administrative Code, Rule No. 560-X-13-.15 and the Alabama Medicaid Billing Manual Chapter 14, DME, for more information.

(28) Podiatrist Service: Covered for QMB or EPSDT referred services only.

(29) Post Surgical Visits:

(a) Hospital Visits: Post-surgical hospital visits for conditions directly related to the surgical procedures are covered by the surgical fee and cannot be billed separately the day of, or up to 62 days post surgery.

(b) Office Visits: Post-surgical office visits for procedures directly related to the surgical procedure are covered by the surgical fee and are not separately covered the day of, or up to 62 days post surgery, and cannot be billed separately, e.g. suture removal.

(c) Visits by Assistant Surgeon or Surgeons: Not covered.

(30) Preventive Medicine: The Medicaid program does not cover preventive medicine other than EPSDT screening.

(31) Prosthetic Devices: External prosthetic devices are not a covered benefit under the Physician's Program. Internal prosthetic devices (i.e., Smith Peterson Nail, pacemaker, vagus nerve stimulator, etc.) are a covered benefit only when implanted during an inpatient hospitalization. The cost of the device is reimbursed through the payment of the inpatient hospital per diem rate and is not separately reimbursable.

(32) Psychiatric Services: Office visits for psychiatric services are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Psychiatric Evaluation or Testing: Are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations shall be limited to one per calendar year, per provider, per recipient.

(b) Psychotherapy Visits: Shall be included in the annual office visit limit. Office visits shall not be covered when billed in conjunction with psychotherapy codes.

(c) Psychiatric Services: Under the Physicians' Program shall be confined to use with psychiatric diagnosis (290-319) and must be performed by a physician.

(d) Hospital Visits: Are not covered when billed in conjunction with psychiatric therapy on the same day.

(e) Services Rendered by Psychologist: See Chapter 11 (EPSDT) for specific information.

(f) Psychiatric Day Care: Not a covered benefit under the Physicians' Program.

(33) Second Opinions: Office visits for second opinions are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Payment is made in accordance with the provider's reasonable charge profile allowance for an initial office visit for the appropriate level of service.

(b) Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.

(34) Self-Inflicted Injury: Covered.

(35) Surgery

(a) Cosmetic: Covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member.

(b) Elective: Covered when medically necessary.

(c) Multiple:

1. When multiple and/or bilateral surgical procedures, which add significant time or complexity are performed at the same operative session, payment will be made for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure. This also applies to laser surgical procedures. Exceptions are noted in Rule No. 560-X-6-.14, Limitations on Services.

2. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g. excision of previous scar or puncture of ovarian cyst) are performed during the same operative session, the reimbursement will be included in that of the major procedure only.

3. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated surgical procedure.

4. CPT defined Add On codes are considered for coverage only when billed with the appropriate primary procedure code.

5. Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. For Medicaid approved modifiers, refer to the Alabama Medicaid Provider Manual.

(36) Telephone Consultations: Not covered.

(37) Therapy: Office visits for therapy are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Occupational and Recreational Therapies: Not covered.

(b) Physical Therapy: Is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician and provided in a hospital setting. See Rule No. 560-X-7-.12 for further requirements of coverage.

(c) Group Therapy: Shall be a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally.

(1) Group Therapy is included in the annual office visit limit.

(2) Group Therapy is not covered when performed by a case worker, social services worker, mental health worker, or any counseling professional other than a physician.

(d) Speech Therapy: The patient must have a speech related diagnosis, such as stroke (CVA) or partial laryngectomy. To be a covered benefit speech therapy must be prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting, or in a nursing home is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician.

(e) Family Therapy: Shall be a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation which justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is included in the annual office visit limit. Family Therapy is not covered when performed by a case worker, social service worker, mental health worker, or any counseling professional other than a physician.

(38) Transplants: See Rule No. 560-X-1-.27 for transplant coverage.

(39) Ventilation Study: Covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record should contain all of the following:

(a) Graphic record;

(b) Total and timed vital capacity;

(c) Maximum breathing capacity;

(d) Always indicate if the studies were performed with or without a bronchodilator.

(40) Well-Baby Coverage: Covered only on the initial visit, which must be provided within eight (8) weeks of the birth.

(41) Work Incentive: A claim stating physical examination for a child to be put into a day-care center for mother to work is a covered procedure. (Must state "Work Incentive Program.")

Author: Mary Timmerman, Associate Director, Medical Services Division
Statutory Authority: Title XIX, Social Security Act; 42 CFR, Sections 405.310(k), 440.50, et seq.; State Plan.
History: Rule effective October 1, 1982. Amended April 15, 1983; June 5, 1983; July 8, 1983; November 10, 1983; April 12, 1984; June 8, 1984; October 9, 1984; January 8, 1985; May 8, 1985; June 8, 1985; July 9, 1985; September 9, 1985; January 22, 1986; April 11, 1986; December 1, 1986; March 12, 1987; June 10, 1987; June 10, 1988; October 12, 1988; July 13, 1989; May 15, 1990; June 14, 1990; October 13, 1990; April 17, 1991; July 1, 1991; October 12, 1991; January 1, 1992; April 14, 1992; March 15, 1994; January 12, 1995; January 1, 1987; January 14, 1987; March 12, 1987; October 11, 1996; January 14, 1997, and October 11, 2000. **Amended**: Filed March 20, 2002; effective June 14, 2002. **Amended**: File February 18, 2003; effective May 16, 2003. **Amended:** Filed January 22, 2004; effective April 16, 2004. **Amended**: Filed August 20, 2004; effective November 16, 2004. **Amended:** Filed December 17, 2004, effective March 17, 2005.

Rule No. 560-X-6-.14. Limitations on Services.

(1) Within each calendar year each recipient is limited to no more than a total of 14 physician office visits in offices, hospital outpatient settings, nursing homes, or Federally Qualified Health Centers. Visits counted under this quota will include, but not be limited to, visits for: prenatal care, postnatal care, family planning, second opinions, consultations, referrals, psychotherapy (individual, family, or group), for ESRD services not covered by the monthly capitation payment, and care by ophthalmologists for eye disease. Physician visits provided in a hospital outpatient setting that have been certified as an emergency do not count against the annual office visit limit.

(a) If a patient receives ancillary services in a doctor's office, by the physician or under his/her direct supervision, and the doctor submits a claim only for the ancillary services but not for the office visit, then the services provided will not be counted as a visit.

(b) For further information regarding outpatient maintenance dialysis and ESRD, refer to 560-X-6-.19 and Chapter 24.

(c) New patient office visit codes shall not be paid to the same physician or the same physician group practice for a recipient more than once in a three-year period.

(2) Physician services to hospital inpatients. In addition to the office visits referred to in paragraph (1) above, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider.

(a) Physician hospital visits are limited to one visit per day, per recipient, per provider.

(b) Physician(s) may bill for inpatient professional interpretation(s) when that interpretation serves as the official and final report documented in the patient’s medical record.

Professional interpretation may be billed in addition to a hospital visit if the rounding physician also is responsible for the documentation of the final report for the procedure in the patient's medical record. Professional interpretation may not be billed in addition to hospital visits if the provider reviews results in the medical record or unofficially interprets medical, laboratory, or radiology tests. Review and interpretation of such tests and results are included in the evaluation and management of the inpatient._Medicaid will cover either one hospital visit or professional interpretation(s) up to the allowed benefit limit for most services. Refer to the Alabama Medicaid Provider Manual for additional guidelines.

(c) Professional interpretations for lab and x-ray (CPT code 70000 through 80000 services) in the inpatient setting should be billed only by the specialist responsible for the official medical record report of interpretation. Professional interpretations performed by physicians of other specialties for services in this procedure code range are included in the hospital visit reimbursement.

(d) Professional interpretations for lab and x-ray services performed in an outpatient setting are considered part of the evaluation and management service and may not be billed in addition to the visit. Professional interpretations may be billed separately only by the specialist responsible for the official medical record report of interpretation. Only one professional interpretation per x-ray will be paid. Claims paid in error will be recouped.

(e) Professional interpretations for lab and x-ray services performed in an office setting are included in the global fee and should not be billed separately.

(f) A physician hospital visit and hospital discharge shall not be paid to the same physician on the same day. If both are billed, only the discharge shall be paid.

(3) Eyecare: Refer to Chapter Seventeen of this Code.

(4) Orthoptics: Orthoptics may be prior authorized by the Alabama Medicaid Agency when medically necessary.

(5) Telemedicine: Telemedicine services are covered for limited specialties and under special circumstances. Refer to the Alabama Medicaid Provider Manual, Chapter 28 for details on coverage.

(6) Telephone consultations: Telephone consultations are not authorized.

(7) Prior authorized services: These are subject to all limitations of the Alabama Medicaid Agency Program.

(8) Post surgical benefits: See Rule No. 560-X-6-.13.

(9) Surgery: When multiple and/or bilateral procedures are billed in conjunction with one another and meet the CPT's definition of "Format of Terminology" (bundled or subset), and/or comprehensive/component (bundled) codes, then the procedure with the highest allowed amount will be paid while the procedure with the lesser allowed amount will not be considered for payment as the procedure is considered an integral part of the covered service.

(a) Operating microscope procedure coverage is limited. For details on coverage, refer to the Physician Chapter of the Alabama Medicaid Provider Manual.

(b) Mutually exclusive procedures are defined as those codes that cannot reasonably be performed in the same session and are considered not separately allowable or reimbursable. An example of this would be an abdominal and vaginal hysterectomy billed for the same recipient on the same date of service.

(c) Incidental procedures are defined as those codes which are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. An example of this would be lysis of adhesions during the same session as an abdominal surgery.

(d) Casting and strapping codes as defined in the CPT and billed in conjunction with related surgical procedure codes are considered not separately allowable or reimbursable as the fracture repair or surgical code is inclusive of these services.

(e) Laparotomy Codes are covered when the laparotomy is the only surgical procedure during an operative session or when performed with an unrelated surgical procedure.

Author: Mary Timmerman, Associate Director, Medical Services Division
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 441.57, 441.56, Part 401, et seq.; State Plan, 42CFR Section 410.78.
History: Rule effective October 1, 1982. Amended July 8, 1983; February 8, 1984; October 9, 1984; January 8, 1985; March 11, 1985; June 8, 1985; September 9, 1985; December 1, 1986; March 12, 1987; July 10, 1987; January 12, 1990; December 12, 1990; January 1, 1992; April 14, 1992; March 15, 1994; January 12, 1995, and December 11, 2000; Amended: Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed February 18, 2003; effective May 16, 2003. **Amended**: Filed May 20, 2003; effective August 18, 2003. **Amended**: Emergency Rule filed and effective April 9, 2004. **Amended**: Filed April 21, 2004; effective July 16, 2004. **Amended**: Filed August 20, 2004; effective November 16, 2004. **Amended**: Filed December 17, 2004, effective March 17, 2005. **Amended**: Filed November 18, 2009; effective February 15, 2010.

Rule No. 560-X-6-.15. Reserved.

Rule No. 560-X-6-.16. Billing of Medicaid Recipients by Providers.

(1) A provider may bill Medicaid recipients for the copay amount, for Medicaid noncovered services and for services provided to a recipient who has exhausted his/her yearly limitations. Conditional collections to be refunded post payment by Medicaid and partial charges for balance of Medicaid allowed reimbursement are not permissible. Billing recipient for services not paid by Medicaid due to provider correctable errors on claims submission or untimely filing is not permissible.

Authority: Title XIX, Social Security Act, 42 C.F.R. Section 447.15, Et seq.; State Plan. Amended July 9, 1984, June 8, 1985, and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.17. Copayment (Cost-Sharing).

(1) Medicaid recipients are required to pay, and physician providers are required to collect, the designated copayment amount on each physician visit. The copayment amount does not apply to services provided for the following:

(a) Pregnancy
(b) Nursing home residents
(c) Inpatient hospital visits
(d) Recipients under 18 years of age
(e) Emergencies
(f) Surgery fees
(g) Physical therapy
(h) Family planning

(2) A provider may not deny services to any eligible individual due to the individual's inability to pay the cost-sharing amount imposed.

Authority: Title XIX, Social Security Act; 42 C.F.R., 447.50, 447.53, 447.55, Et seq.; and State Plan Attachment 4.18-A. Rule effective June 8, 1985. Amended July 9, 1985 and March 12, 1987. Effective date of this amendment March 15, 1994.

Rule No. 560-X-6-.18. Critical Care.

(1) When caring for a critically ill patient in which the constant attention of the physician is required, the appropriate critical care procedure code must be billed. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidance and clarification.

(2) The actual time period, per day, spent in attendance at the patient's bedside, or performing duties specifically related to that patient, irrespective of breaks in attendance, must be documented in the patient's medical record.

(3) Only the following individual procedures related to critical care may be billed:

(a) Procedure code 99360 (stand by) and either procedure code 99221, 99222, or 99223 (initial hospital care) may be billed once with each hospital stay.

(b) An EPSDT screening may be billed in lieu of the initial hospital care (Procedure code 99221, 99222, or 99223).

(c) Procedure code 99082 (transportation/escort of patient) may be billed only by the attending physician. Residents or nurses who escort a patient may not bill either service.

(4) Pediatric and Neonatal Critical Care

The purpose of the following policy statements is to provide assistance to providers seeking to bill procedures for critical care. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidance and clarification.

(a) Pediatric and neonatal critical care codes begin with the day of admission and may be billed once per patient, per day, in the same facility.

(b) The pediatric and neonatal critical care codes include management, monitoring and treatment of the patient, including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

(c) Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes should be billed.

(d) Refer to the Alabama Medicaid Provider Manual for guidelines on what additional procedures may be billed in conjunction with critical care. General guidelines are:

1. Initial history and physical or EPSDT screen may be billed in conjunction with 99293 or 99295. Both may not be billed. One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes.

2. Standby (99360) or resuscitation (99440) at delivery or attendance at delivery (99436) may be billed in addition to critical care. Only one of the codes may be billed in addition to critical care.

3. Subsequent Hospital Care codes (99231-99233) may not be billed.

4. Critical care is considered to be an evaluation and management service. Although usually furnished in a critical or intensive care unit, critical care may be provided in any inpatient health care setting. Services provided which do not meet critical care criteria should be billed under the appropriate hospital care codes. If a recipient is readmitted to the NICU/ICU, the provider must be the primary physician in order for NICU/ICU critical care codes to be billed again.

5. Transfers to the pediatric unit from the NICU cannot be billed using neonatal critical care codes.

6. Global payments encompass all care and procedures which are included in the rate. Physicians may not perform an EPSDT screen and refer to partner or other physician to do procedures. All procedures which are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.

7. Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as defined in the Alabama Medicaid Provider Manual. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient. Consultation and critical care cannot be billed on the same patient on the same day.

(5) Intensive (Non-Critical) Low Birthweight Services

The purpose of the following policy statement is to provide assistance to neonatology providers seeking to bill for intensive (non-critical) low birthweight services. Refer to the CPT and the Alabama Medicaid Provider Manual for additional guidelines and

clarification. Intensive (non-critical) low birthweight services codes are used to report care subsequent to the day of admission provided by a neonatologist directing the continuing intensive care of the very low birthweight infant who no longer meets the definition of being critically ill. Low birthweight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting.

Arthur: Mary Timmerman, Associate Director, Medical Services Division
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 440.50; CPT-4.
History: Rule effective May 9, 1986. Amended March 12, 1987, October 12, 1988, and June 12, 1991. Emergency rule effective January 1, 1992. Amended April 14, 1992. Emergency rule effective May 7, 1992. Amended August 12, 1992, March 13, 1993 and March 15, 1994.
Amended: Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed May 20, 2003; effective August 18, 2003. **Amended:** Filed December 17, 2004, effective March 17, 2005.

Rule No. 560-X-6-.19. Physician Services for End-Stage Renal Disease (ESRD).

(1) All physician services rendered to each outpatient maintenance dialysis patient provided during a full month on an ongoing basis without interruption of the treatment regime (uninterruptedly) shall be billed on a monthly capitation basis. The monthly capitation payment is limited to once per month, per recipient, per provider.

(2) Physician services rendered to each outpatient maintenance dialysis patient not performed consecutively (interruptedly) during a full month, i.e., preceding and/or following the period of hospitalization, are allowed. Please refer to the physician's chapter of the Provider Manual for further details.

(3) Services not covered by the monthly capitation payment (MCP) and which are reimbursed in accordance with usual and customary charge rules are limited to:

(a) Declotting of shunts.

(b) Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these services.

(c) Nonrenal related physician services. These services may be furnished either by the physician providing renal care or by another physician. They may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.

(4) Refer to the Renal Dialysis chapter for further details.

Author: Brenda Vaughn, Program Manager, Medical Services Program.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.542, and Federal Register dated July 2, 1986.
History: Emergency Rule effective January 1, 1987. Amended January 14, 1987, March 12, 1987, and March 15, 1994. Amended: Filed February 18, 2003; effective May 16, 2003.

Chapter 7. Hospitals.

Rule No. 560-X-7-.01 Hospital Program – General

(1) The Title XIX (Medicaid) Plan for Alabama provides for inpatient care for adults and children and for preventive, diagnostic, therapeutic, rehabilitative, or palliative outpatient services under certain conditions which are enumerated in detail in the Plan.
Except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or additional inpatient days that have been authorized for deliveries or children who have been referred for treatment as a result of an EPSDT screening, the first 16 days in a calendar year will be reimbursed on an established per diem rate. Subsequent days will be factored into the establishment of cost as described in Chapter 23, Hospital Reimbursement.

(2) Refer to Chapter 1 and Chapter 11 for details on benefit limits for medically necessary services which are provided as a result of an EPSDT screening referral.

Author: Jerri Jackson, Associate Director, Institutional Services
Statutory Authority: State Plan; Attachment 3.1-A, pp 1 ~~& 1.1~~; 42 CFR Sections 440.10, 440.20, 441.57; Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272). Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).
History: Rule effective October 1, 1982. Amended July 8, 1983; February 8, March 12, June 8, October 9, 1984; June 8, September 9, 1985; October 11, 1986; September 9, 1987; July 1, 1988; October 12, 1988; January 1, 1989; March 14, 1989; July 1, 1989; January 12, 1990; October 1, 1990; January 15, 1991; July 1, 1991; January 14, 1992; and April 11, 1997. **Amended:** Emergency Rule filed and effective April 9, 2004. **Amended:** Filed April 21, 2004; effective July 16, 2004. **Emergency Rule:** Filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-7-.02. Participation.

(1) Eligibility. In order to participate in the Title XIX Medicaid program and to receive Medicaid payment for inpatient and outpatient hospital services, a hospital provider must meet the following requirements:

(a) Be certified for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital. Hospital types are identified on the Hospital Request for Certification in the Medicare/Medicaid Program (HCFA-1514) or its successor.

(b) Be licensed as a hospital by the State of Alabama in accordance with current rules contained in the Alabama Administrative Code Chapter 420-5-7.

(c) Be in compliance with Title VI of the Civil Rights Act of 1964 and with Section 504 of the Rehabilitation Act of 1973.

(d) Submit a letter requesting enrollment.

(e) Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new facility.

(f) Execute the Alabama Medicaid Provider Agreement for participation in the Medicaid program.

(g) Submit a written description of an acceptable utilization review plan currently in effect.

(2) Enrollment. Application by hospitals for participation in the Alabama Medicaid program is made to:

Provider Enrollment
EDS
P.O. BOX 244035
Montgomery, AL 36124

(a) The effective date of enrollment cannot be earlier than the date of the Medicare certification.

(3) Participating out-of-state (border) hospitals are subject to all program regulations and procedures that apply to participating Alabama hospitals and shall submit copies of their annual certification from HCFA, State licensing authority, and other changes regarding certification. "Border" is defined as within 30 miles of the Alabama state line.

(4) Nonparticipating hospitals are those hospitals which have not executed an agreement with Alabama Medicaid covering their program participation, but provide medically necessary covered out-of-state services.

(a) All Medicaid admissions to participating and nonparticipating facilities are subject to program benefits and limitations based on current Medicaid eligibility.

(b) Out-of-state prior authorization is required for organ transplants and select surgical procedures. (Refer to Rule No. 560-X-1-.27 and Rule No. 560-X-6-.13 respectively.

(5) The Fiscal Agent will be responsible for enrolling any Title XVIII (Medicare) certified hospital that wishes to enroll as a Qualified Medicare Beneficiary (QMB-only) provider.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan, Section 2.7, 4.11, 4.10 and Attachment 7.2A; Title XIX, Social Security Act; 42CFR Sections 405.191, 431.51, 431.52, 431.107, 440.10, 440.20. Medicare Catastropic Coverage Act of 1988 (Public Law 100-360).
History: Rule effective October 1, 1982. Amended November 10, 1983; November 11, 1985; December 10, 1986; February 9, 1988; July 13, 1989; October 13, 1992; April 11, 1997. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.03. Inpatient Benefits.

(1) An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he will remain at least overnight and occupy a bed (even though it later develops he can be discharged or is transferred to another hospital and does not use a bed overnight.)

(2) The number of days of care charged to a recipient for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in reporting days of care for the recipients, even if the hospital uses a different definition of day for statistical or other purposes.

(3) Medicaid covers the day of admission, but not the day of discharge. If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day.

(4) Newborn well-baby nursery charges will be covered by an eligible mother's claim for up to ten days nursery care for each baby if the mother is in the hospital and is otherwise entitled to such coverage.

(a) For well-baby nursery charges, revenue codes 170 and 171 are reflected on the mother's claim in conjunction with her inpatient stay for the delivery. The hospital per diem rate includes charges for the mother and newborn.

(b) Newborn “well-baby” care is not separately billable. Nursery charges for “boarder babies”, infants with no identified problems or condition whose mothers have been discharged, were never admitted to the hospital, or are not otherwise eligible for Medicaid are not separately billable.

(5) Newborns admitted to accommodations other than the well-baby nursery must be eligible for Medicaid benefits in their own right (claim must be billed under the baby's own name and Medicaid number). Example: If an infant is admitted to an intensive care or other specialty care nursery, the claim must be billed under the infant's number even if the mother is still an inpatient.

(a) If revenue codes 172, 175 or 179 are to be billed, the newborn infant's condition must meet the medical criteria established for each revenue code.

(b) Revenue codes 172, 175 and 179 are to be billed utilizing the infant's name and Medicaid number. These charges are to be billed on a separate UB-04 claim form. ICD-9-CM diagnosis codes identifying the conditions that required the higher level of care must be on the claim.

(c) Medicaid will routinely monitor the coding of neonatal intensive care claims through post-payment review.

(6) Hospitals should refer to the Alabama Medicaid Provider Manual (Hospital Chapter 19) for the criteria established for each revenue code.

Author: Jerri Jackson, Associate Director, Institutional Services.

Authority: State Plan, Attachment 3.1-A, 4.19-A; Title XIX, Social Security Act; 42 C.F.R. Section 409.10, Subpart B.
History: Rule effective October 1, 1982. Amended November 10, 1983, March 8, 1986; April 11, 1986, and November 10, 1987. Effective date of this amendment is April 11, 1997.
Amended: Filed March 22, 2010; effective June 16, 2010.

Rule No. 560-X-7-.04. Bed and Board in Semi-Private Accommodations.

(1) Medicaid will pay for semi-private accommodations (two, three, or four bed accommodations). When accommodations other than semi-private are furnished, the following rules will govern:

(a) Private rooms medically necessary - Payment may be made for private room or other accommodations more expensive than semi-private only when such accommodations are medically necessary. Private rooms will be considered medically necessary when the patient's condition requires him to be isolated for his own health or that of others. The term isolation may apply when treating a number of physical or mental conditions. These include communicable diseases which require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatments are likely to alarm or disturb others in the same room. Payment will be made for the use of intensive care facilities where medically necessary. In order for the private room to be covered by Medicaid, the following conditions must be met:

1. The physician must certify at the time of admission or within 48 hours of the onset of the need for a private room, and the specific medical condition requiring a private room.

2. Such certification must appear in the hospital records as a written order by the physician.

3. At the time the physician certifies the need for continued hospitalization, the private room must also be recertified as being medically necessary. Medicaid will not cover a private room on the basis of a retroactive statement of medical necessity by the physician. At the time the medical necessity for a private room ceases, the patient should be placed in the type accommodation covered by Medicaid.

(2) Private rooms not medically necessary - When accommodations more expensive than semi-private are furnished the patient because at the time of admission less expensive accommodations are not available or because the hospital has only private accommodations, Medicaid may pay for the semi-private accommodations. THE PATIENT IS NOT TO BE BILLED OR REQUIRED TO PAY THE DIFFERENCE. When accommodations more expensive than semi-private are furnished the patient at his request, the hospital may charge the patient no more than the difference between the customary charge for the most prevalent semi-private accommodations and the more expensive accommodations at the time of admission. The hospital must require the patient to sign a form requesting the more expensive accommodation and agreeing to pay the difference. This form must be on file for review if questions arise regarding payment of private room charges.

(3) Customary charges mean amounts which the hospital is uniformly charging patients currently for specific services and accommodations. The most prevalent rate for semi-private accommodations is the rate which applies to the greatest number of semi-private beds.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982.
Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.05. Nursing and Other Services.

(1) Nursing and other related services, use of hospital facilities, and the medical social services ordinarily furnished by the hospital for the care and treatment of inpatients are covered.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982.

Rule No. 560-X-7-.06. Drugs and Biologicals.

(1) Drugs and biologicals for use in the hospital which are ordinarily furnished by the hospital for the care and treatment of inpatients are covered.

(2) Take-home drugs and medical supplies are not covered in the Medicaid Program.

(3) A patient may, on discharge from the hospital, take home remaining amounts of drugs which have been supplied for him either on prescription or doctor's order, if continued administration is necessary, since they already would have been charged to his account by the hospital.

(4) Medically necessary take-home drugs should be provided by written prescription either through the hospital pharmacy or any other Medicaid approved pharmacy.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982.

Rule No. 560-X-7-.07. Supplies, Appliances, and Equipment.

(1) Supplies, appliances, and equipment furnished by the hospital solely for the care and treatment of a recipient during an inpatient stay in the hospital are covered as part of the hospital per diem payment.

(2) Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not generally covered as inpatient hospital services. A temporary or disposable item, however, which is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply is covered as part of the hospital per diem payment.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42CFR Section 401, et seq.

History: Rule effective October 1, 1982. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.08. Hemodialysis.

(1) Hemodialysis for chronic renal cases is provided under the Medicaid Program when the patient is not authorized this care under Medicare.

(2) Refer to Chapter One, Rule No. 560-X-1-.27, of the Administrative Code for kidney transplant coverage.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 401, et seq. Rule effective October 1, 1982. Rule amended April 11, 1997. Effective date of this amendment is January 12, 1998.

Rule No. 560-X-7-.09. Blood.

(1) Charges for whole blood or equivalent quantities of packed red cells are not allowable since Red Cross provides blood to hospitals; however, blood processing and administration is a covered service.

Authority: State Plan, Attachment 3.1-A; Title XIX, Social Security Act; 42 C.F.R. Section 409.87. Rule effective October 1, 1982, and November 10, 1987. Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.10. Sterilization and Hysterectomy.

(1) Surgical procedures for male and female recipients as a method of birth control are covered services under the conditions set forth in the chapter pertaining to Family Planning.

(2) Any Alabama Medicaid hospital claim that relates to any sterilization or hysterectomy must have documentation attached to it showing or consisting of a consent form or an acknowledgement of receipt of hysterectomy information. These attachments must meet the criteria set forth under the sterilization and hysterectomy regulations. See the Physician' Chapter and the Family Planning Chapter for further details.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.11. Abortions.

(1) Payment for abortions under the Medicaid Program is subject to the conditions in the chapter pertaining to Physicians. See the Physicians' Chapter for further details.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Effective date of amendment May 11, 1987.

Rule No. 560-X-7-.12. Physical Therapy.

(1) Physical therapy is a covered service based on medical necessity. Physical therapy services that do not require the professional skills of a qualified physical therapist to perform or supervise are not considered medically necessary. Physical therapy is covered:

(a) in a hospital outpatient setting, and

(b) for acute conditions.

(2) Physical therapy performed in an outpatient hospital setting does not count against the recipient's three non-emergency outpatient visit limits.

(3) Rehabilitative services are not covered. Rehabilitative services are defined as the restoration to useful activity of people with chronic physical or disabling conditions.

(4) Physical therapy services are limited to those CPT codes listed in the Hospital Billing Manual. Maximum units for daily and annual limits are noted for each covered service.

(5) Physical therapy records will be reviewed retrospectively as part of the Provider Review Program. The following medical criteria must be met and the treatment plan must be stated in the recipient's medical record. If the medical criteria are not met and/or documentation of the treatment plan is not stated in the medical record relevant claims will be recouped. The medical criteria are:

(a) Physical therapy is covered for acute conditions only. An acute condition is a new diagnosis which has been made within three months of the beginning date of the physical therapy treatments.

(b) Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition where the diagnosis is made more than three months before the beginning date of the physical therapy treatments.

(c) An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition.

(6) In addition to the recipient meeting the above stated medical criteria, the provider of service is responsible for developing a plan of treatment. This plan of treatment must be readily available at all times for review in the recipient's medical record. The plan of treatment should contain, but is not limited to, the following information:

(a) Recipient's name

(b) Recipient's current Medicaid number

(c) Diagnosis(es)
(d) Date of onset or the date of the acute exacerbation, if applicable
(e) Type of surgery performed, if applicable
(f) Date of surgery, if applicable
(g) Functional status prior to and after physical therapy is completed
(h) Frequency and duration of treatment
(i) Modalities
(j) For ulcers, the location, size, and depth should be documented.

(7) The plan of treatment must be signed by the physician who ordered the physical therapy and the therapist who administered the treatments. The information contained in the treatment plan must be documented in the recipient's medical record.

Author: Lynn Sharp, Associate Director, Policy Development Unit.
Statutory Authority: State Plan, Attachment 3.1-A; Title XIX, Social Security Act; 42CFR Sections 440.10, 440.20, 440.50.
History: Rule effective July 1, 1991. Amended October 12, 1991; April 11, 1997. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.13. Adverse Events, Hospital-Acquired Conditions, and Present on Admission Indicators.

(1) This rule applies to inpatient hospital admissions beginning dates of admission on or after July 1, 2010.

(2) Adverse Events are the events that must be reported to Medicaid by the hospital. To be reportable, these events must meet the following criteria:

(a) The event must be reasonably preventable as determined by a root cause analysis or some other means.

(b) The event must be within the control of the hospital.

(c) The event must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.

(d) The error or event must result in significant harm. The events for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.

(e) Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

(3) Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from adverse events.

(4) Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient hospital admission occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered POA.

(5) Details on billing claims and reporting Adverse Events, Present on Admission and Hospital-Acquired Conditions may be obtained in the Alabama Medicaid Provider Manual (Hospital-Chapter 19).

Author: Jerri Jackson, Associate Director, Institutional Services.
Statutory Authority: Section 1862(a)(1)(A) of the Social Security Act; Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, Section 5001(c) of the Deficit Reduction Act of 2005.
History: New Rule: Filed March 22, 2010; effective June 16, 2010.

Rule No. 560-X-7-.14. Dental Services

Items and services in connection with the care, treatment, filling, removal or replacement of teeth, or structures directly supporting the teeth are covered for those recipients eligible for treatment under the Early and Periodic Screening, Diagnosis, and Treatment Program. See Chapter 15, Dental Services for details.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Sections 441.50, 441.56. Rule effective October 1, 1982. Amended March 11, 1985 and June 8, 1985. Emergency rule effective December 5, 1986. Effective date of this emergency rule March 12, 1987. Effective date of this amendment April 13, 1987.

Rule No. 560-X-7-.15. Inpatient Non-Covered Services.

(1) Items and Services for which there is no legal obligation to pay - Free services are excluded from coverage, (e.g., chest x-rays provided without charge by health organizations).

(2) Items and Services which are required as a result of war - Those required as a result or act of war, occurring after the effective date of the patient's current coverage are not covered.

(3) Personal comfort items, such as radio, television, telephone, beauty and barber services, which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

(4) Routine physical check-ups required by third parties, such as insurance companies, business establishments or other government agencies are not covered.

(5) Braces, orthopedic shoes, corrective shoes, or other supportive devices for the feet are not covered.

(6) Custodial care or sitters are not covered.

(7) Cosmetic surgery or expenses in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the function of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic service, which coincidentally also serves some cosmetic purpose.

(8) Items and services to the extent that payment has been made, or can reasonably be expected to be made under a Workman's Compensation Law, or plan of the United States, or a state may not be paid for by Medicaid.

(9) Inpatient hospitalization for routine diagnostic evaluations that could be satisfactorily performed in the outpatient department of the hospital, or in a physician's office or appropriate clinic is not covered.

(10) Psychological evaluations and testing and psychiatric evaluations are not covered by Medicaid except where actually performed by a physician in person.

(11) Speech therapy is not covered by Medicaid unless actually performed by a physician in person.

(12) Reserved Bed Charges - There is no provision under the Alabama Medicaid Program for payment of reserved inpatient hospital beds for patients on a pass for a day or more.

(13) Inpatient services provided specifically for a procedure that requires prior approval is not covered unless prior authorization from Medicaid for the procedure has been obtained by the recipient's physician. In the event that the recipient is receiving other services which require inpatient care at the time the procedure is performed, any charges directly related to the procedure will be non-covered and subject to recoupment. Additionally, all admissions must meet the Adult and Pediatric Inpatient Care Criteria (SI/IS).

Author: Jerri Jackson, Associate Director, Institutional Services.
Statutory Authority: 42CFR Section 405.310, 405.311, 405.314, 405.316.
History: Rule effective October 1, 1982. Amended June 14, 1990, and April 11, 1997. Amended: Filed June 18, 1999; effective September 9, 1999. **Amended:** Filed March 22, 2010; effective June 16, 2010.

Rule No. 560-X-7-.16. Utilization Review for Inpatient Hospital Admissions and Concurrent Stays.

(1) Medicaid will utilize Alabama Medicaid Adult and Pediatric Inpatient Care Criteria (SI/IS) for utilization review, billing and reimbursement purposes.

(a) It is the hospital's responsibility to utilize its own physician advisor.

(b) The attending physician and/or resident may change an order up to 30 days after discharge, as long as the patient met criteria for inpatient or observation services.

(c) Refer to Chapter 3 of this Administrative Code for the fair hearings/appeals process.

(2) For admissions and continued stays on or after July 1, 2010, Medicaid will require in-state and border hospital providers to report dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

(a) Dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy must be reported on the UB-04.

(3) Inpatient psychiatric and rehabilitation services in an acute care facility will be exempt from reporting dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

(4) The Alabama Medicaid Local Policy is available on the Alabama Medicaid website.

(5) A percentage of admissions and concurrent stay charts will be reviewed by the Alabama Medicaid Agency and a Quality Improvement Organization contracted by the Agency.

(6) All in-state and border hospitals must submit Medical Care Evaluation (MCE) Studies (i.e. Performance Improvement Studies) and Utilization Review (UR) Plans to the contracted Quality Improvement Organization every year upon request.

Author: Jerri Jackson, Associate Director, Institutional Services.
Statutory Authority: State Plan; 42 C.F.R. 456, Subpart C; Section 1902 (d), Title XIX, Social Security Act.
History: Emergency rule effective April 1, 1983, permanent rule effective July 8, 1983. Effective date of this amendment October 12, 1988. **Amended:** Filed March 22, 2010; effective June 16, 2010.

Rule No. 560-X-7-.17. Outpatient Hospital Services.

(1) "Outpatient hospital services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician/dentist at a licensed hospital.

(2) For the two-year period beginning October 1, 2009 and ending September 30, 2011, all outpatient claims will be paid as encounters.

(a) Outpatient Hospital encounters are generally face-to face contacts between a patient and a health professional for medically necessary services.

(b) An encounter may also be classified as non-patient hospital services such as specimens and blood samples sent to the hospital for performance of tests.

(c) Claims for ER and noncertified outpatient visits must be all inclusive.

(d) Hospitals should span bill for services that are provided over an established period of time, such as chemotherapy, radiation services, and physical therapy services.

(e) Each hospital shall continue to bill for outpatient services as it did prior to the implementation of the encounter payment methodology.

(f) One encounter rate will be paid per ICN (internal control number).

(3) Medical services provided in the outpatient department must be identified and the specific treatment documented in the medical record.

(4) Outpatient surgical services are those covered procedures commonly performed on an inpatient basis that may be safely performed on an outpatient basis. Only those surgeries included on the Medicaid outpatient hospital fee schedule will be covered on an outpatient basis. Surgeries included on the Medicaid outpatient surgical list are reimbursable when provided on an inpatient basis if utilization review criteria are met.

(a) Surgical procedures that are not listed on Medicaid's outpatient fee schedule may be sent to the Institutional Services Unit to be considered for coverage in the outpatient setting if medically necessary and the procedure is approved by the Medical Director.

(b) Refer to the Outpatient Hospital Fee Schedule on the Medicaid website for a list of covered surgical codes.

(5) Outpatient hospital visits are limited to three per calendar year with exceptions referenced below. Only those procedures covered for outpatient hospital billing may be submitted for payment. Reimbursement includes the use of the facility and no additional facility fee may be billed.

(a) All outpatient hospital services provided by the hospital from admission to discharge of the outpatient will constitute a visit.

(b) Specimens and blood samples sent to the hospital for performance of tests are classified as non-patient hospital services since the patient does not directly receive services from the hospital; therefore, this does not constitute a visit and is not subject to program limitations.

(c) Providers who send specimens to independent laboratories for analysis may bill Medicaid for a collection fee. This fee shall not be paid to anyone who has not actually collected the specimen from the patient.

(d) Routine venipuncture for collection of laboratory specimens may be billed only when sending blood specimens to another site for analysis. The collection fee may not be billed if the lab work is done at the same site where the specimen was drawn.

(e) Hospital labs may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. Payment may be made to the referring laboratory but only if one of the following conditions is met:

1. the referring laboratory is located in, or is part of, a rural hospital;
2. the referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity; or
3. the referring laboratory does not refer more than 30 percent of the clinical laboratory tests for which it receives requests for testing during the year (not counting referrals made under the wholly-owned condition described above).

(f) Outpatient visits solely for chemotherapy, therapeutic radiation, radiology and/or laboratory services are unlimited and do not count against benefit limitations. Radiology services are defined as CPT-4 procedure codes 70000 through 79999. Laboratory services are defined as procedure codes 80000 through 89999.

(g) Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure indicated on the Medicaid outpatient hospital fee schedule on the Medicaid website. This rate is established as a facility fee for the hospital and includes all nursing and technician services; diagnostic, therapeutic and pathology services; pre-op and post-op lab and x-ray services; materials for anesthesia; drugs and biologicals; dressings, splints, casts, appliances, and equipment directly related to the surgical procedure.

(h) Multiple surgical procedures on the claim will be reimbursed the lesser of charges or 100% of the fee on the pricing file for the initial procedure and the lesser of charges or 50% of the fee on the pricing file for subsequent procedures.

(6) "Emergency services" are services that are furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition. A "certified emergency" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part."

(7) Non-certified visits to the emergency room are considered outpatient visits and are counted against the outpatient benefit limit of three visits per calendar year.

(8) Emergency medical services provided in the hospital emergency room must be certified and signed by the attending physician, at the time the service is rendered, and documented in the medical record if the claim is filed as a "certified emergency."

(9) Certified emergency visits are unlimited if the medical necessity is properly documented and certified in the medical record by the attending physician at the time services are rendered. Certified emergency visits do not require a PMP referral.

(10) UB 04 claims for emergency department services must be coded with the appropriate CPT code according to the criteria established by Medicaid to be considered for payment

(11) Outpatient dialysis services are covered under the End-Stage Renal Disease Program and cannot be reimbursed as an outpatient hospital service. See Chapter 24 for details.

(12) Inpatient Admission after Outpatient Hospital Services-If the patient is admitted as an inpatient before midnight of the day outpatient services were rendered at the same hospital all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient will be considered as the first day of inpatient hospital services.

(13) Outpatient Observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

(a) Outpatient observation is defined as the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to no more than 23 hours.

(b) Outpatient observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit limit, unless documented as a certified emergency by the attending physician at the time of service.

(c) An observation unit is defined as an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires either additional observation before a decision is made about admission to the hospital or prolonged patient care is rendered. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient. The following guidelines apply:

1. A physician's order is required for admission and discharge from the observation unit.
2. A physician must have personal contact with the patient at least once during the observation stay.
3. Patients in the observation unit must be monitored by a registered nurse or an employee under his/her direct supervision.
4. Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as services provided.
5. A recipient must be in the observation unit a minimum of three hours but no more than 23 hours.

(d) Outpatient observation charges must be billed in conjunction with the appropriate emergency room facility fee.

(e) Observation coverage is billable in hourly increments only; therefore, a recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed.

(f) The first three hours of observation are included in the emergency room facility fee.

(g) Observation procedure codes (99218-99220) should be billed according to the instructions in the current CPT manual. The appropriate code may be billed up to 20 units (unit=one hour) per day.

(h) Ancillary charges (lab work, x-ray, etc.) may be billed with the emergency room facility fee and observation charge.

(i) If the observation spans midnight and the recipient is discharged from the observation unit the following day, the provider should bill all observation charges using the date of admission to the observation unit on the outpatient claim form.

(j) If a recipient is admitted to the hospital from outpatient observation, all outpatient charges must be combined and billed with the inpatient charges. The provider should indicate the date of admission to the inpatient hospital as the admission date on the claim form for inpatient services.

(k) Outpatient observation charges cannot be billed in conjunction with outpatient surgery or critical care.

(l) Medical records will be reviewed retrospectively by Medicaid to ensure compliance with the above stated guidelines and criteria.

(14) Medicaid will cover two obstetrical ultrasounds per year for Medicaid recipients that are not participating in the maternity care program. Additional ultrasounds may be approved if a patient's documented medical condition meets the criteria established by Medicaid. Providers should contact Medicaid's Prior Authorization Unit in writing to request approval for additional ultrasounds.

Author: Jerri Jackson, Associate Director, Institutional Services.
Statutory Authority: State Plan, Attachment 4.19-B, 3.1-A, page 1; Title XIX, Social Security Act, Section 1833(h) (5) (A); 42CFR Sections 440.20, 440.170, 440.255, 447.321.
History: Rule effective October 1, 1982. **Amended**: October 1, 1983; June 9, 1986; February 9, 1987; May 1, 1987; August 10, 1987; November 10, 1987; August 10, 1988; January 12, 1990; July 1, 1990; October 1, 1991; December 12, 1991; January 14, 1992; April 11, 1997; June 18, 1999; September 10, 1999; December 16, 1999; March 13, 2000; April 20, 2000; July 11, 2000. **Amended**: Filed December 18, 2000; effective March 12, 2001. **Amended**: Filed March 22, 2010; effective June 16, 2010. **Amended:** Emergency rule filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-7-.18. Patient Signature

(1) While a recipient signature is not required on individual claim forms, all providers must obtain a signature to be kept on file, (e.g., release forms or sign in sheets), as verification that the recipient was present on the date of service for which the provider seeks payment. Exceptions to the recipient signature requirement are listed below.

(a) When there is no personal recipient/provider contact, such as laboratory or radiology services.

(b) Illiterate recipients may make their mark, for example, "X", witnessed by someone with their dated signature after the phrase "witnessed by."

(c) If the patient cannot sign due to physical or mental impairment or because of age, an authorized person may sign for the patient indicating his/her relationship to the patient.

(2) The signature alone or on other insurance forms is not acceptable for payment under Medicaid.

(3) The signature and accompanying authorization and certification must be available for review by Medicaid and/or the Medicaid fiscal agent.

(4) When the acceptable signature is not available or is on an incorrect form and payment has been made, the funds covering this period of care will be recouped.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Amended January 14, 1992. Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.19. Repealed

Author: Lynn Sharp, Associate Director, Policy Development Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42CFR Section 401, et seq.
History: Rule effective October 1, 1982. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.20. Hospital-Based Physicians, Submission of Claims.

Reference Chapter 6 Physicians and Chapter 23 Hospital Reimbursement Program for details.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Sections 405.401, 405.522, 405.523. Rule effective October 1, 1982. Amended January 8, 1985 and June 8, 1985. Effective date of this amendment May 11, 1987.

Rule No. 560-X-7-.21. Outpatient and Inpatient Tests.

(1) Based on PL 97-35, the "Omnibus Budget Reconciliation Act of 1981, "Section 2164(a) and 42 CFR Part 441.12, effective October 1, 1981, Medicaid will pay only for laboratory tests or x-rays or any other type of test provided in inpatient or outpatient hospital facilities which have been ordered by the attending physician or other staff physician. There will be no payment made for tests under "standing orders" or "routine orders."

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Effective date of this amendment is April 11, 1997.

Rule No. 560-X-7-.22. Claim Filing Guidelines

(1) For claim filing guidelines, refer to Chapter 5, (Filing Claims) of the Provider Manual or Chapter 19 (Hospital) of the Provider Manual.

(2) Claims containing fragmentation of services may be recouped through post-payment review.

Author: Jerri Jackson, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 419-E, page 1, Title XIX, Social Security Act; 42 CFR 447.45, et seq.
History: Rule effective October 1, 1982. Amended November 11, 1985, and April 11, 1997. Amended: Filed June 18, 1999; effective September 9, 1999. **Emergency Rule:** Filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-7-.23. Third party Payment Procedures.

For guidelines on submitting claims to Medicaid when a third party is involved, refer to the Hospital Billing Manual.

Author: Lynn Sharp, Associate Director, Policy Development Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42CFR, Section 401, et seq.
History: Rule effective October 1,1982. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.24. Sending Bills and Statements to Medicaid Recipients.

(1) Providers should not send recipients bills or statements for covered services once that recipient has been accepted as a Medicaid patient.

(2) Providers may send a notice to the recipient stating their claim is still outstanding if the notice indicates in bold letters: "THIS IS NOT A BILL."

(3) Providers are responsible for follow-up with the fiscal agent or Medicaid on any billing problems or unpaid claims.

(4) The Recipients are not responsible for the difference between charges billed and the amount paid by Medicaid for covered charges services.

(5) Providers agree to accept the amount paid by Medicaid as payment in full.

(6) Recipients may be billed only for the allowable copayment amount, for services not covered by Medicaid, or when benefits have been exhausted.

(7) Providers may not deny services to any eligible recipient due to the recipient's inability to pay the allowable copayment amount.

Author: Lynn Sharp, Associate Director, Policy Development Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42CFR Sections 447.15, 447.50, 447.55.
History: Rule effective October 1, 1982. Amended July 9, 1984; June 8, 1985, and April 11, 1997. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.25. Prior Authorization

(1) Out-of-State Referrals - Prior authorization will be required for organ transplants and select surgical procedures. (Refer to Rule No. 560-X-1-.27 and Rule No. 560-X-6-.13 respectively).

(2) Dental Hospitalization - See Chapter 15, Dental Services, for details.

(3) Additional inpatient days for deliveries, beyond the initial days paid may be authorized upon request for recipients who have exceeded their initial 16 paid days.

(a) A ten digit authorization number will be issued for those stays that are medically necessary and meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria.

(b) Additional days other than for active labor, delivery, and inpatient postpartum care will not be authorized.

Author: Jerri Jackson, Associate Director, Institutional Services
Authority: State Plan, Attachment 3.1A; Title XIX, Social Security Act; 42 C.F.R. Section 431.25.
History: Rule effective October 1, 1982. Amended July 8, October 1, November 10, 1983; May 9, 1984; June 9, October 11, 1986; April 1, 1988 and October 12, 1988. Emergency Rule effective January 1, 1989. Amended March 14, 1989; April 17, 1990; January 15, 1991; October 12, 1991, and October 13, 1992. Effective date of this amendment is April 11, 1997.
Emergency Rule: Filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-7-.26. Medicare/Medicaid Eligible Recipients.

(1) Inpatient - Refer to Rule 560-X-1-.14. for details.

(2) Outpatient - Part B. Payment for outpatient crossover claims shall be based on the lesser of the coinsurance and/or deductible amount or the Medicare allowed amount times the outpatient percentage rate minus the Medicare paid amount.

Authority: State Plan, Attachment 3.1-A, 3.2-A; 42 C.F.R., Section 409.60, .80, & .83; Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360). Rule effective October 1, 1982. Rule amended October 9, 1984; March 7, 1986, April 11, 1986, September 8, 1986, and January 1, 1988. Emergency rule effective February 1, 1989. Amended May 12, 1989. Effective date of this amendment is January 11, 1996.

Rule No. 560-X-7-.27. Split Billing (Inpatient Claims).

(1) Due to the reimbursement methodology described in Chapter 23 for_ inpatient hospital benefits on a calendar year basis, it shall be necessary for each hospital to "split bill" for inpatient services (each year) as of December 31.

Author: Jerri Jackson, Associate Director, Institutional Services
Authority: State Plan, 419A; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq.
History: Rule effective October 1, 1982. Amended November 10, 1983. Emergency rule effective July 1, 1987. Amended September 9, 1987. Effective date of this amendment is April 11, 1997. **Emergency Rule:** Filed and effective September 2, 2010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-7-.28. Copayment (Cost Sharing).

(1) The Medicaid recipient shall pay the allowable copayment amount for each inpatient admission under the Medicaid program, except for the designated exemptions. The copayment amount does not apply to services provided for the following:

(a) Recipients under 18 years of age
(b) Pregnancy
(c) Renal dialysis
(d) Emergencies
(e) Family planning
(f) Chemotherapy
(g) Radiation therapy
(h) Nursing home residents

(2) The Medicaid recipient shall pay the allowable copayment amount for each outpatient visit received under the Medicaid program, except for designated exemptions. The copayment amount does not apply to services provided for the following:

(a) Recipients under 18 years of age
(b) Pregnancy
(c) Renal dialysis
(d) Emergencies
(e) Family planning
(f) Chemotherapy
(g) Radiation therapy
(h) Physical therapy
(i) Nursing home residents

Author: Lynn Sharp, Associate Director, Policy Development Unit.
Statutory Authority: State Plan, Attachments 4.18-A; 42CFR Sections 447.15, 447.50, 447.55.
History: Rule effective June 8, 1985. Amended September 13, 1994. Amended: Filed June 18, 1999; effective September 9, 1999.

Rule No. 560-X-7-.29. Payment of Outpatient Hospital Services.

(1) Payment for all outpatient hospital services will be from approved rates as established by Medicaid.

(2) Publicly owned hospitals and hospitals which predominately treat children under the age of 18 years may be paid at an enhanced payment. These payments shall not exceed combined payments for providing comparable services under comparable circumstances under Medicare.

Authority: State Plan, 42 CFR 447.321, 447.325, Title XIX Social Security Act. Rule effective September 8, 1986. Effective date of this amendment October 1, 1994. Emergency rule effective January 1, 1995. Effective date of this amendment March 15, 1995.

Rule No. 560-X-7-.30 Post-Hospital Extended Care Services.

(1) Inpatient hospital services rendered at an inappropriate level of care (lower than acute) are considered post-hospital extended care services. The patient must have received a minimum of three consecutive days of acute care services in the hospital requesting Post-Hospital Extended Care (PEC) reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. (Refer to Chapter 10). Such medically necessary services include, but are not limited to:

(a) Nursing care provided by or under the supervision of a registered nurse on a 24-hour basis;

(b) Bed and board in a semi-private room. Private accommodations may be utilized if the patient's condition requires that he/she be isolated, the facility has no ward or semi-private rooms, or all ward or semi-private rooms were full at the time of admission and remain so during the recipient's stay;

(c) Medically necessary over-the-counter (non-legend) drug products ordered by physician. Generic brands are required unless brand name is specified in writing by the attending physician;

(d) Personal services and supplies ordinarily furnished by a nursing facility for the comfort and cleanliness of the patient;

(e) Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W, and normal saline);

(f) Services ordinarily furnished to an inpatient of a hospital.

(2) In order for such services to be reimbursed, the hospital must submit a written request to Medicaid to receive a provider number that will allow them to use up to ten beds for these services for hospitals with up to 100 beds, with an additional ten beds per each additional 100 beds. Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available within a reasonable proximity, and the recipient must require on a regular basis two of the following medically necessary services:

(a) Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis;

(b) Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis;

(c) Nasopharyngeal aspiration required for the maintenance of a clear airway;

(d) Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, or other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created;

(e) Administration of tube feedings by naso-gastric tube;

(f) Care of extensive decubitus ulcers or other widespread skin disorders;

(g) Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse;

(h) Use of oxygen on a regular or continuing basis;

(i) Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, post operative, or chronic conditions; or

(j) Receive routine medical treatment as a comatose patient.

(3) To establish medical necessity, an application packet must be furnished to the Medicaid Admissions Program within 60 days from the date Medicaid coverage is requested. The 60 days will be calculated from the date the application is received and date stamped in the Admissions Program. All applications with a date greater than 60 days old will be assigned an effective date that is 60 days prior to the Admissions Program date stamp. No payment will be made for the days prior to the assigned Admissions Program effective date. The facility will be informed in writing of the assigned effective date. The application packet will consist of:

(a) A fully completed Medicaid Status Notification Form XIX-LTC-4 including all documentation certified by the applicant's attending physician to support the need for nursing home level of care.

(b) Documentation certifying the patient has received inpatient acute care services for no less than three consecutive days during the current hospitalization in the requesting hospital prior to the commencement of post-extended care services. These days must have met the Medicaid Agency's approved acute care criteria; and

(c) Documentation certifying contact was made with each nursing facility within a reasonable proximity to determine bed non-availability prior to or on the date coverage is sought, and every 15 days thereafter;

(4) In order to continue Post-Hospital Extended Care eligibility, recertification must be made every 30 days. Nursing facility bed non-availability must be forwarded along with request for recertification.

(5) Reimbursement for post-hospital extended care services will be made on a per diem basis at the average unweighted per diem rate paid by Medicaid to nursing facilities for routine nursing facility services furnished during the previous fiscal year ended June 30. There shall be no separate year end cost settlement. Refer to Chapter 22 of the Alabama Administrative Code for details on rate computation.

(6) A provider must accept as payment in full the amount paid by Medicaid plus any patient liability amount to be paid by the recipient and further agrees to make no additional charge or charges for covered services.

(7) Any day a patient receives such post-hospital extended care services will be considered an acute care inpatient hospital day. These beds will not be considered nursing facility beds.

(8) These services are not subject to the inpatient hospital benefit limitations. At this level of care, post-hospital extended care days are unlimited if a nursing home bed is not located as described in paragraphs (2) and (3)(d) above.

Author: Beverly Rotton, Project Development/Policy Unit, Long Term Care Division
Statutory Authority: Social Security Act, Title XIX; State Plan; and 42 C.F.R. Section 447.253(b).
History: Rule effective July 13, 1994. Amended May 11, 1995 and April 11, 1997. Amended: Filed August 20, 1999; effective November 10, 1999.

Chapter 8. Independent Rural Health Clinic Services

Rule No. 560-X-8-.01. Independent Rural Health Clinic Services.

(1) Independent Rural Health Clinics must be Medicare certified and contracted with the Alabama Medicaid Program, and be in compliance with Federal, State and Local Laws.

(2) Services covered under the Independent Rural Health Clinic program are any medical service typically furnished by a physician in an office or in a physician home visit. Limits are the same as for the Physician Program.

(3) Independent Rural Health Clinic services are reimbursable if:

(a) performed by a physician,

(b) performed by nurse practitioner, physician assistant, certified nurse midwife, or clinical social worker as an incident to a physicians service,

(c) a physician, nurse practitioner, physician assistant, or certified nurse midwife is available to furnish patient care at all times the clinic operates,

(d) a nurse practitioner, physician assistant, or certified nurse midwife is available to furnish patient care at least 50 percent of the time the clinic operates.

(4) Independent Rural Health Clinic services must also conform to any state requirements for the nurse practitioner, physician assistant, and certified nurse midwife regarding the scope or conditions of their practice.

(5) The Independent Rural Health Clinic must be under the medical direction of a physician. Except in extraordinary circumstances, the physician must be physically present for sufficient periods of times, at least every 72 hours for non-remote sites and every seven (7) days for remote sites (a remote site being defined as a site more than 30 miles away from the primary supervising physician's principal practice location), to provide medical care services, consultation, and supervision in accordance with Medicare regulations for Rural Health Clinics. When not physically present, the physician must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances must be documented in the records of the clinic.

(6) The fiscal agent will be responsible for enrolling all Title XVIII (Medicare) certified Independent Rural Health Centers that wish to enroll as Qualified Medicare Beneficiary (QMB) only providers.

(7) In order to participate in the Title XIX Medicaid Program and to receive Medicaid payment, an Independent Rural Health Clinic (IRHC) must:

(a) Request an enrollment packet from Fiscal Agent as an IRHC Provider. Services to be provided should be identified in the enrollment application.

(b) Submit a copy of the following documentation of Medicare certification; the Centers for Medicare and Medicaid Services (CMS) letter assigning the Medicare Provider

number and establishing the initial encounter rate. A copy of the facilities budget cost report must be sent to Medicaid's Alternative Services Division.

(c) Submit a copy of the CMS Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate or waiver.

(d) Be operating in accordance with applicable Federal, State, and local laws.

(e) Certify compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and with the Age Discrimination Act of 1975.

(f) Execute a provider contract with the Alabama Medicaid Agency.

(8) The effective date of the enrollment of an IRHC will be the latter of the following: the first day of the month in which the written request for enrollment was received; or the date of Medicare certification.

Author: Ginger Collum, Program Manager, Clinic/Ancillary Services
Statutory Authority: State Plan; 42 C.F.R. Section 491.8, Et seq.; Title XIX, Social Security Act; Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360); Section 6213 of the Omnibus Budget Reconciliation Act of 1989.
History: Rule effective October 1, 1982. Rule amended July 13, 1989, June 14, 1990, May 13, 1993, September 11, 1993, March 14, 1996 and August 11, 1997. **Amended:** Filed January 18, 2002; effective April 18, 2002. **Amended:** Filed July 21, 2003; effective October 16, 2003.

Rule No. 560-X-8-.02. Other Ambulatory Services.

(1) The following services are covered as other ambulatory services furnished in an Independent Rural Health Clinic and are not billed as Rural Health Clinic services:

(a) Dental Services;
(b) Eyeglasses;
(c) Hearing aids;
(d) Prescribed devices;
(e) Prosthetic devices; and
(f) Durable medical equipment.

(2) The services listed in Rule No. 560-X-8-.02 (1) are covered separately under the respective program areas reimbursement practices. Refer to the Administrative Code Chapters 15, 17, 19, 13, 14, 43, 11, and 50 respectively for enrollment procedures and policies.

Authority: State Plan; Attachment 3.1-A, Page 1.2.;42 C.F.R. Section 401, et seq.; Section 440.20; Title XIX, Social Security Act. Rule effective October 1, 1982. Rule amended May 13, 1993. Effective date of this amendment is January 12, 1995.

Rule No. 560-X-8-.03. Reimbursement.

Independent Rural Health Clinics will be reimbursed at the reasonable cost rate per visit (encounter) established for the clinic by Medicaid.

Encounters are all-inclusive and all services provided for the visit are included in the reimbursement rate. The only exceptions are claims for laboratory services and for the technical component of EKGs and radiology services.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: 42 C.F.R., Section 447.371, et seq.; State Plan for Medical Assistance, Attachment 4.19-B, page 1.
History: Rule effective October 1, 1982. Amended December 6, 1984, May 13, 1993, and May 16, 2001. Amended: Filed January 18, 2002; effective April 18, 2002. **Amended:** Filed May 20, 2005; effective August 16, 2005.

Rule No. 560-X-8-.04. Change of Ownership.

Medicaid must be notified within thirty (30) days of the date of Independent Rural Health Clinic ownership change. The existing contract will be automatically assigned to the new owner, and the new owner shall then be required to execute a new contract with Medicaid as soon as possible after the change of ownership, but in no event later than thirty (30) days after the new owner receives notification of Medicare certification. If the new owner fails to execute a new contract with Medicaid within this time period, then this contract shall terminate.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Effective date of this amendment is May 13, 1993.

Rule No. 560-X-8-.05. Medicare Deductible and Coinsurance.

Deductible and/or Co-insurance will be reimbursed up to the full amount of the Medicaid encounter rate.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: State Plan, Title XIX, Social Security Act; 42 C.F.R. Section 405.2425.
History: Rule effective October 1, 1982. Amended October 13, 1987. Amended: Filed January 18, 2002; effective April 18, 2002.

Rule No. 560-X-8-.06. Copayment (Cost-Sharing).

(1) Medicaid and Medicare/Medicaid related recipients are required to pay and independent rural health clinics are required to collect the established copayment amount for each clinic encounter.

(2) The cost-sharing requirement does not apply to services provided for the following:

(a) Recipients under 18 years of age;
(b) Emergencies;
(c) Pregnancy;
(d) Family Planning;
(e) Nursing home residents;
(f) America Indians

(3) A provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: 42 C.F.R. Section 447.50, Section 447.53, Section 447.55, et seq.; State Plan, Attachment 4.18-A.
History: Rule effective June 8, 1985. Effective date of this amendment is May 13, 1993. Amended Filed October 20, 2010; effective February 22, 2011.

Rule No. 560-X-8-.07. Billing Recipients.

(1) A provider agrees to accept as payment in full the amount paid by the State, plus any copayment amount required to be paid by the recipients, for covered items and further agrees to make no additional charge or charges for covered items to the recipient.

(2) A provider may bill the recipient for the copayment amount and for noncovered Medicaid services.

(3) A provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount.

Authority: 42 C.F.R. Section 447.15; State Plan, Attachment 4.18-A. Rule effective June 8, 1985.

Chapter 9. Independent Laboratory Services

Rule No. 560-X-9-.01. Independent Laboratory Services- General.

1. The Alabama Medicaid Agency will pay for services provided by independent laboratories that are enrolled by contract under the following conditions:

    a. The services must be medically necessary.

    b. The patient must be eligible for Medicaid at the time the services are rendered.

Authority: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 440.30. Rule effective October 1, 1982. Amended June 5, 1983, July 9, 1984, October 15, 1990, January 15, 1991. Effective date of this amendment October 13, 1998.

Rule No. 560-X-9-.02. Covered Services.

1. Laboratory services are professional and technical laboratory services - (a) ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law; (b) ordered by a physician but provided by a referral laboratory; (c) provided in an office or similar facility other than a hospital outpatient department or clinic; and (d) provided by a laboratory that meets the requirements for participation in Medicare.

    a. Laboratory services are restricted to those that are described by procedures in the CPT manual (80000 series) or one of the locally assigned HCPCS codes used only by Medicaid to supplement the listing in the CPT manual.

    b. Providers will be paid only for covered services which they are certified to perform and which they actually perform.

    c. Physicians who send specimens to independent laboratories for analysis, and laboratories that provide specimen collection services for referral to other laboratories, may bill a collection fee. This fee shall not be paid to any provider that has not actually collected the specimen from the patient.

Routine venipuncture for collection of laboratory specimens may be billed only when sending blood specimens to another site for analysis. The collection fee may not be billed if the lab work is done at the same site the specimen was drawn, or in a lab owned, operated, or financially associated with the site in which the specimen was drawn.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 CFR, Section 440.30.
History: Rule effective October 1, 1982. Amended October 15, 1990; January 15, 1991; October 13, 1998.
Amended: Filed September 21, 2000; effective December 11, 2000

Rule No. 560-X-9-.03. Participation Requirements.

1. Independent laboratories must meet the following requirements for participation in the Alabama Medicaid program:

    a. Be certified for participation with Medicare.

    b. Have a valid CLIA certification (i.e., clinical labs).

    c. Have a Physician's Supervisory Certification and utilize certified technicians for ultrasounds, Doppler services, and non-invasive peripheral vascular studies (i.e., physiological labs).

    d. Must be independent of any hospital, clinic, or physician's office.

    e. Be licensed in the state where located, when it is required by that state.

    f. Submit to routine audits by Medicaid.

    g. Complete an application with all required attachments.

    h. Sign a provider agreement.

    i. Sign a Direct Deposit Authorization.

    j. Sign a Civil Rights Statement of Compliance.

    k. Effective date of enrollment will be the date of issuance of license. If

licensure is not required in the state of residence, the effective date of enrollment will be the date of CLIA certification. However, providers who request enrollment more than 120 days after the above applicable date will be enrolled on the first day of the month the request for enrollment is received.

Author: Ginger Collum, Program Manager, Clinic/Ancillary Services
Statutory Authority: State Plan; 42 C.F.R Section 440.30; 493.2; Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended October 15, 1990, January 15, 1991, October 13, 1998. Amended: Filed December 17, 2001, effective March 15, 2002.

Rule No. 560-X-9-.04. Reserved.

Rule No. 560-X-9-.05. Reserved.

Rule No. 560-X-9-.06. Claims Filing Guidelines.

1. For time limits on claims submission, refer to the Medicaid Provider Manual, Independent Laboratory chapter.

2. Claims for lab services must contain a valid diagnosis code.

3. Claims submitted must contain the provider number of the lab that actually performed the service. Claims must not be submitted using any other provider's number, such as the provider number of the referring physician or hospital.

4. All organ and disease oriented panels must include the tests listed with no substitutions. If only part of the tests included in a defined panel are performed, the panel code should not be reported. If additional tests to those indicated in a panel are performed, those tests should be reported separately in addition to the panel code. If two panels overlap, the physician or laboratory will be required to unbundle one of the panels and bill only for the tests that are not duplicative.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR, Section 405.401, et seq.
History: Rule effective October 13, 1998. Amended: Filed September 21, 2000; effective December 11, 2000.

Rule No. 560-X-9-.07. Reserved.

Rule No. 560-X-9-.08. Third Party Payment Procedures.

For guidelines on submitting claims to Medicaid when a third party is involved, refer to the Medicaid Provider Manual, Independent Laboratory chapter.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR, Section 401, et seq.
History: Rule effective October 13, 1998. Amended: Filed September 21, 2000; effective December 11, 2000.

Rule No. 560-X-9-.09. Sending Bills and Statements to Medicaid Recipients.

1. Providers should not send recipients bills or statements for covered services once the recipient has been accepted as a Medicaid patient.

2. Providers may send a notice to the recipient stating their claim is still outstanding if the notice indicates in bold letters, "**THIS IS NOT A BILL**".

3. Providers are responsible for follow-up with the fiscal agent or Medicaid on any billing problems or unpaid claims.

4. Providers agree to accept the amount paid by Medicaid as payment in full.

5. Recipients are not responsible for the difference between charges billed and the amount paid by Medicaid for covered services.

6. Recipients may be billed only for the allowable copayment amount, for services not covered by Medicaid, or when benefits have been exhausted.

7. Providers may not deny services to any eligible recipient due to the recipient's inability to pay the allowable copayment amount.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Sections 447.15, 447.50, 447.55. Rule effective October 13, 1998.

Rule No. 560-X-9-.10. Reserved.

Rule No. 560-X-9-.11. Reserved.

Rule No. 560-X-9-.12. Non-Covered Services.

Medicaid will not pay packing and handling charges for referred laboratory services. Payment for referred tests will be made to the referred laboratory only at the normal rate. This policy shall be monitored through postpayment review by Medicaid.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30, & 440.50; Deficit Reduction Act of 1984. Rule effective October 1, 1982. Amended November 11, 1985, January 8, 1986, October 15, 1990, January 15, 1991, October 13, 1992. Effective date of this amendment October 13, 1998.

Chapter 10 Long Term Care

Rule No. 560-X-10-.01. Definitions.

(1) Nursing Facility - An institution which is primarily engaged in providing nursing care and related services for residents who require medical and nursing care, rehabilitation services for the rehabilitation of injured, disabled or sick persons, or on a regular basis health related care and services to individuals who because of their mental or physical condition require care and services which may be made available to them only through institutional facilities. A facility may not include any institution that is for the care and treatment of mental disease except for services furnished to individuals age 65 and over.

(2) Intermediate Care Facility for the Mentally Retarded (ICF/MR) - An institution that is primarily for the diagnosis, treatment or rehabilitation of the mentally retarded or persons with related conditions and provides in a protected residential setting, ongoing evaluations, planning, 24 hour supervision, coordination and integration of health or rehabilitative services to help each individual function at their greatest ability.

(3) Institution for Mental Disease (IMD) –
(a) An institution that is licensed as a mental institution; or
(b) More than fifty percent (50%) of the patients are receiving care because of disability in functioning resulting from a mental disease. Mental diseases are those listed under the heading of Mental Disease in the Diagnostic and Statistical Manual of Mental Disorders, Current Edition, International Classification of Diseases, adopted for use in the United State (ICD 9) or its successors, except for mental retardation.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 431.1, et seq., Section 483.5 and Section 435.1009.
History: Rule effective October 1, 1982. Rule amended December 18, 1986. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.02. Long Term Care Program - General.

(1) The Medical Assistance (Title XIX) Plan for Alabama provides for medically necessary nursing facility services, rendered in a facility which meet the licensure requirements of the Department of Public Health and the certification requirements of Title XIX and XVIIII of the Social Security Act and complies with all other applicable state and federal laws and regulations and with accepted professional standards and principles that apply to professionals providing services.

(2) Nursing facilities must be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(3) Nursing facilities must comply with Title VI of the Civil Rights Act of 1964, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973 and with the Disabilities Act of 1990.

(4) Nursing facilities must maintain identical policies and practices regarding transfer, discharge and covered services for all residents regardless of source of payment.

(5) Nursing facilities must have all beds in operation certified for Medicaid participation.

(6) Nursing facilities must be certified for Medicare Title XVIII as a condition of participation in the Alabama Medicaid Program.

(7) For nursing facilities participating in Medicaid two agreements must be made by representatives of the nursing facilities. These agreements outline the methods by which nursing facility care is rendered to Medicaid patients. These two documents are entitled Provider Agreement and Nursing Facility/Resident Agreement.

(a) The Provider Agreement is executed between the nursing facility and the Alabama Medicaid Agency and details the requirements imposed on each party to the agreement. It is also the document which requires the execution of the Nursing Facility/Resident Agreement.

(b) The Nursing Facility/Resident Agreement is executed between the nursing facility representative and the patient or his personal representative and details the requirements imposed on each party to the agreement. This agreement must be executed for each resident on admission and annually thereafter. If the liability amount changes for the resident or if there are policy changes, the agreement must be signed and dated as these changes occur. Two copies of the agreement will be prepared; one shall be given to the resident or personal representative and one shall be retained by the nursing facility.

(8) Nursing facilities shall accept as payment in full, those amounts paid for covered services in accordance with the State Plan.

(9) Nursing facilities must not require a third party guarantee of payment to the facility as a condition of admission, or expedited admission, or continued stay in the facility. Nursing facilities may require an individual who has legal access to a resident's income or resources available to pay for nursing facility care, to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

Author: Dittra S. Graham, Administrator, LTC Program Management.
Statutory Author: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 401, et seq., Section 483.75.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.03. Enrollment and Participation.

(1) All nursing facilities that desire to enroll and participate in the Alabama Title XIX Medicaid nursing facility program and to receive Medicaid payment for services provided for Medicaid residents must meet the following requirements:

(a) Possess certification for Medicare Title XVIII.

(b) Submit a budget to the Alabama Medicaid Agency Provider Reimbursement Division for the purpose of establishing a per diem rate.

(2) Execute a Provider Agreement with Medicaid.

(3) Execute a Nursing Facility/Resident Agreement with Medicaid residents.

Author: Dittra S. Graham, Administrator, LTC Program Management.
Statutory Author: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 401, et seq., Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).
History: Rule effective October 1, 1982. Rule amended June 16, 1989. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.04. Covered and Noncovered Services.

(1) Services included in basic (covered) nursing facility charges.

(a) All nursing services to meet the total needs of the resident including treatment and administration of medications ordered by the physician.

(b) Personal services and supplies for the comfort and cleanliness of the resident. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the resident to maintain a clean, well-kept personal appearance such as hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleanser, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing, basic personal laundry and incontinence care.

(c) Room (semiprivate or ward accommodations) and board, including special diets and tubal feeding necessary to provide proper nutrition. This service includes feeding residents unable to feed themselves.

(d) All services and supplies for incontinent residents, including linen savers and diapers.

(e) Bed and bath linens.

(f) Nursing and treatment supplies as ordered by the resident's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W).

(g) Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, oxygen concentrators and other items generally provided by nursing facilities for the general use of all residents.

(h) Materials for prevention and treatment of bed sores.

(i) Medically necessary over-the-counter (non-legend) drug products ordered by a physician, with the exception of over-the-counter insulin covered under the Pharmacy program. Generic brands are required unless brand name is specified in writing by the attending physician.

(j) Laundry services of personal apparel.

(2) Special (noncovered) services not ordinarily included in basic nursing facility charges. These services, drugs, or supplies may be provided by the nursing facility or by arrangement with other vendors by mutual agreement between the resident, or their personal representative and the nursing facility.

(a) Prosthetic devices, splints, crutches, and traction apparatus for individual residents.

(b) If payment is not made by Medicare or Medicaid, the facility must inform the resident/personal representative that there will be a charge, and the amount of the charge. Listed below are general categories and examples of items:

1. Telephone;
2. Television/radio for personal use;
3. Personal comfort items, including smoking materials, notions and novelties, and confections;
4. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
5. Personal clothing;
6. Personal reading matter;
7. Gifts purchased on behalf of a resident;
8. Flowers and plants;
9. Social events and entertainment offered outside the scope of the required activities program;
10. Noncovered special care services such as privately hired nurses or aides;

11. Private room, except when therapeutically required (for example: isolation for infection control).
12. Specially prepared or alternative foods request instead of the food generally prepared by the facility;
13. Beauty and barber services provided by professional barbers and beauticians.

(c) Services of licensed professional physical therapist.
(d) Routine dental services and supplies.
(e) Tanks of oxygen.

(3) Other services are provided by Medicaid under separate programs, including prescription drugs as listed in the Alabama Drug Code Index, hospitalization, laboratory and x-ray services, and physician services.

Author: Laura Walcott, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 401, et seq.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Effective date of this amendment February 13, 1991. Emergency rule effective September 6, 1991. **Amended:** December 12, 1991 and April 14, 1994. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed April 20, 2005; effective July 15, 2005.

Rule No. 560-X-10-.05. Reservation of Beds.

(1) Payment for Reservation of Beds in Long Term Care Facilities.

(a) Neither Medicaid patients, nor their families, nor their sponsor, may be charged for reservation of a bed for the first four days of any period during which a Medicaid patient is temporarily absent due to admission to a hospital. Prior to discharge of the patient to the hospital, the patient, the family of the patient or the sponsor of the patient is responsible for making arrangements with the nursing home for the reservation of a bed and any costs associated with reserving a bed for the patient beyond the covered four day hospital stay reservation period. The covered four day hospital stay reservation policy does not apply to:

1. Medicaid-eligible patients who are discharged to a hospital while their nursing home stay is being paid by Medicare or another payment source other than Medicaid;
2. Any non-Medicaid patients;
3. A patient who has applied for Medicaid but has not yet been approved; provided that if such a patient is later retroactively approved for Medicaid and the approval period includes some or all of the hospital stay, then the nursing home shall refund that portion of the bed hold reservation charge it actually received from the patient, family of the patient or sponsor of the patient for the period that would have been within the four covered days policy; or
4. Medicaid patients who have received a notice of discharge for non-payment of service.

(2) Upon entering the hospital or the resident being placed on therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy. The bed-hold policy specifies when a resident is permitted to return and resume residence in the nursing facility.

(3) When a nursing facility is contacted by the hospital notifying them that the resident is ready for release, within the four day bed-hold period, the nursing facility must allow the resident to return to their facility before the bed-hold period expires provided the resident is an appropriate placement for nursing facility care and the nursing facility provides the type of services that meets the needs of the resident. The nursing facility must have documented verifiable evidence in the resident's medical record to indicate that there has been a significant change in the resident's condition, either prior to or during the hospital stay, making re-admission to the nursing facility inappropriate because the nursing facility can no longer meet the needs of the resident. When such a significant change in a resident's condition occurs

prior to discharge to the hospital, the nursing facility should use reasonable efforts to begin to arrange for appropriate placement for the resident prior to transferring the resident to the hospital. If there is documented evidence in the medical record that the nursing facility is refusing to re-admit a resident without valid cause as determined by the Alabama Medicaid Agency, the Alabama Medicaid Agency shall notify the Division of Health Care Facilities, Alabama Department of Public Health, for appropriate enforcement action. If enforcement action ensues and results in program termination, any loss of nursing facility payment during the time that the nursing facility contract is terminated will not be considered a reimbursable Medicaid cost.

(4) A nursing facility or ICF/MR must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave or bed-hold policy is readmitted to the facility immediately upon the first available bed in a semi-private room if the resident requires the services provided by the facility.

(5) Four day bed-hold. If a nursing facility refuses to take a resident back who has been released from the hospital during the four day bed-hold period, provided the resident is an appropriate placement for nursing facility care and the nursing facility provides the type of services capable of meeting the resident's needs, Medicaid may terminate the facility's provider agreement for failing to adhere to the rules set forth in the federal and state bed-hold policy until an acceptable plan of correction is received from the nursing facility. If the Alabama Medicaid Agency determines that the nursing facility has failed to follow the rules set forth in the federal and state bed-hold policies, the Alabama Medicaid Agency shall notify the Division of Health Care Facilities, Alabama Department of Public Health, for appropriate enforcement action. If enforcement action ensues and results in program termination, any loss of nursing facility payment during the time that the nursing facility contract is terminated will not be considered a reimbursable Medicaid cost.

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan Attachment 4.19-C; Title XIX, Social Security Act; and 42 CFR Section 483.12.
History: Rule effective October 1, 1982. Amended October 1, 1990, and February 13, 1991.
Amended: Filed July 20, 1999; effective October 12, 1999. **Amended:** Filed May 22, 2000; effective August 11, 2000. **Amended:** Filed December 17, 2001; effective March 15, 2002. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed March 20, 2008; effective June 18, 2008.

Rule No. 560-X-10-.06. Therapeutic Leave

(1) Payments to nursing facilities may be made for therapeutic leave visits to home, relatives, and friends for up to six days per calendar quarter. A therapeutic leave visit may not exceed three days. Visits may not be combined to exceed the three day limit.

(2) Payments to ICF/MR facilities for therapeutic visits are limited to 14 days per calendar month.

(3) The nursing facility must ensure that each therapeutically indicated visit by a patient to home, relatives, or friends is authorized and certified by a physician.

(4) Medicaid shall not be responsible for the record keeping process involving therapeutic leave.

(5) A nursing facility must provide written notice to the resident and a family member or legal representative of the above specifying the Medicaid policy upon a resident taking therapeutic leave and at the time of transfer of a resident to a hospital.

Author: Marilyn F. Chappelle, Director, Long Term Care Division.
Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 CFR Section 401, et seq., Section 483.12.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed August 21, 2006; effective December 13, 2006.

Rule No. 560-X-10-.07. Review of Medicaid Residents.

(1) The Alabama Medicaid Agency or its designated agent will perform a review of Medicaid nursing home or ICF/MR facility residents' records to determine appropriateness of admission.

(a) A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Alabama Medicaid Agency Long Term Care Admissions/Records Unit within ten working days from receipt of the certified letter shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. The Associate Director of the Long Term Care Admissions/Records Unit may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Associate Director of the Long Term Care Admissions/Records Unit with supporting documentation.

Author: Marilyn F. Chappelle, Director, Long Term Care Division.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR Section 401, et seq., Section 435.1009 and Section 456.1.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed August 21, 2006; effective December 13, 2006.

Rule No. 560-X-10-.08. Physician Certification.

(1) A physician must perform the specific physician services required by state and federal law.

(2) A physician is defined in Section 1861R of the Social Security Act as a doctor of medicine or osteopathy legally authorized to practice medicine and surgery in the state in which he is performing services.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Section 1861R and Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 491.2.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.09. Reimbursement and Payment Limitations.

(1) Reimbursement will be made in accordance with Chapter 22, Alabama Medicaid Administrative Code.

(2) Each nursing facility shall have a payment rate assigned by Medicaid. The patient's available monthly income minus an amount designated for personal maintenance (and in some cases amounts for needy dependents and health insurance premiums) is first applied against this payment rate and Medicaid then pays the balance.

(a) The nursing facility may bill the resident for services not included in the per diem rate (noncovered charges) as explained in this chapter.

(b) Actual payment to the facility for services rendered is made by the fiscal agent for Medicaid in accordance with the fiscal agent billing manual.

(3) Residents with Medicare Part A.

(a) Medicaid may pay the Part A coinsurance for the 21st through the 100th day for Medicare/Medicaid eligible recipients who qualify under Medicare rules for skilled level of care.

(b) An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the 21st through the 100th day. No payment will be made by Medicaid for nursing care in a nursing facility for the first 20 days of care for recipients qualified under Medicare rules.

(c) Nursing facilities must assure that Medicaid recipients eligible for Medicare Part A benefits first utilize Medicare benefits prior to accepting a Medicare/Medicaid recipient as a Medicaid resident.

(d) Residents who do not agree with adverse decisions regarding level of care determinations by Medicare should contact the Medicare fiscal intermediary.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 442.1, et seq., Section 431.151, et seq. and Section 481.1, et seq.
History: Rule effective October 1, 1982. Emergency rule effective July 22, 1988. Amended October 12, 1988. Emergency rule effective October 1, 1990. Amended February 13, 1991; March 13, 1992.
Amended: Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.10. Admission Criteria.

(1) Guidelines for nursing facility admission criteria: The principal aspect of covered care relates to the care rendered. The controlling factor in determining whether a person is receiving covered care is the medical supervision that the resident requires. Nursing facility care provides physician and nursing services on a continuing basis. The nursing services are provided under the general supervision of a licensed registered nurse. An individual may be eligible for care under the following circumstances:

(a) The physician must state "I certify" need for admission and continuing stay.

(b) Nursing care is required on a daily basis.

(c) Nursing services are required that as a practical matter can only be provided in a nursing facility on an inpatient basis.

(d) Nursing service must be furnished by or under the supervision of an RN and under the general direction of a physician.

(2) Listed below, but not limited to, are specific services that a resident requires on a regular basis: (Resident must meet at least two criteria.)

(a) Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment.

(b) Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis.

(c) Nasopharyngeal aspiration required for the maintenance of a clear airway.

(d) Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.

(e) Administration of tube feedings by naso-gastric tube.

(f) Care of extensive decubitus ulcers or other widespread skin disorders.

(g) Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse.

(h) Use of oxygen on a regular or continuing basis.

(i) Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, post operative, or chronic conditions.

(j) Comatose patient receiving routine medical treatment.

(3) The above criteria will be applied to all admissions to a nursing facility with the exception of Medicaid residents who have had no break in institutional care since discharge from a nursing home. These residents need to meet only one of the above criteria.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; P.L. 92-603 and P.L. 98-369; 42 C.F.R. 435.1009 and Section 456.1.
History: Rule effective October 1, 1982. Amended February 8, 1984 and December 6, 1984. Emergency rule effective October 1, 1990, Amended February 13, 1991, and August 12, 1993.
Amended: Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.11. Establishment of Medical Need.

(1) Application of Medicare Coverage:

(a) Nursing facility residents, either through age or disability, may be eligible for Medicare coverage up to 100 days.

(b) Nursing facilities must apply for eligible Medicare coverage prior to Medicaid coverage.

(c) Nursing facilities cannot apply for Medicaid eligibility for a resident until Medicare coverage is discontinued.

(2) Periods of Entitlement.

(a) The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.

(b) An exception to (a) above, is retroactive Medicaid coverage. An individual who has been living in the nursing facility prior to application and has unpaid medical expenses during that time can seek retroactive Medicaid coverage for up to three months prior to financial application if the individual meets all financial and medical eligibility requirements during each of the three prior months.

(c) For a determination of medical eligibility for retroactive Medicaid coverage to be made, the nursing facility should furnish the Long Term Care Admissions/Records Unit with the Form MED-54, attaching all physician's orders, physician's progress notes, and nurse's notes for the period of time in question.

(3) Resident Records

(a) Medicaid Long Term Care Admissions/Records Unit monitors the admission and discharge system and maintains a record for each active patient in the nursing facility.

(b) A file is kept for six (6) years on each resident.

(4) The Medicaid Agency has delegated authority for the initial level of care determination to long term care providers. Medicaid maintains ultimate authority and oversight of this process.

(a) The process to establish medical need includes medical and financial eligibility determination.

1. The determination of level of care will be made by an RN of the nursing facility staff.

2. Upon determination of financial eligibility the provider will submit required data electronically to Medicaid's fiscal agent to document dates of service to be added to the LTC file.

(b) All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews.

1. New Admissions

(i) Medicaid Patient Status Notification (Form 199).

(ii) Form XIX LTC-9. If criterion unstable medical condition is one of the established medical needs the provider must maintain supporting documentation of the unstable condition requiring active treatment in the 60 days preceding admission.

(iii) A fully completed Minimum Data Set.

(iv) PASRR screening information.

2. Readmissions

(i) Medicaid Patient Status Notification (Form 199).

(ii) Updated PASRR screening information as required.

(c) All Medicaid certified nursing facilities for individuals with a diagnosis of MI are required to maintain the following documents in their files. These documents support the medical need for admission or continued stay.

1. New Admissions

(i) Medicaid Patient Status Notification (Form 199).

(ii) Form XIX LTC-9.

(d) All Medicaid certified ICF/MR facilities are required to complete and maintain the following documents in their files for Medicaid retrospective reviews. These documents support the ICF/MR level of care needs.

1. New Admissions.

(i) A fully completed Medicaid Patient Status Notification (Form 199).

(ii) A fully completed ICF/MR Admission and Evaluation Data (Form XIX-LTC-18-22).

(iii) The resident's physical history.

(iv) The resident's psychological history.

(v) The resident's interim rehabilitation plan.

(vi) A social evaluation of the resident.

2. Readmissions

(i) Medicaid Patient Status Notification (Form 199).

(ii) ICF/MR Admission and Evaluation Form.

(e) A total evaluation of the resident must be made before admission to the nursing facility or prior to authorization of payment.

1. An interdisciplinary team of health professionals, which must include the resident's attending physician, must make a comprehensive medical, social, and psychological evaluation of the resident's need for care. The evaluation must include each of the following medical findings; (a) diagnosis; (b) summary of present medical, social, and developmental findings; (c) medical and social family history; (d) mental and physical functional capacity; (e) prognosis; (f) kinds of services needed; (g) evaluation of the resources available in the home, family, and community; and (h) the physician's recommendation concerning admission to the nursing facility or continued care in the facility for residents who apply for Medicaid while in the facility and a plan of rehabilitation where applicable. The assessment document will be submitted with the LTC-9 on new admissions.

(f) All Medicaid certified nursing facilities will have a period of one year from the date of service in which to bill for services. There is no timeliness penalty for submission of information to establish service delivery dates.

(g) Authorization of eligibility by Medicaid physician

1. For all applications for which a medical eligibility cannot be determined, the application should be submitted to the Medicaid Long Term Care Admissions/Records Unit. The Alabama Medicaid Agency physician will review and assess the documentation submitted and make a determination based on the total condition of the applicant. The physician will approve or deny medical eligibility.

2. The LTC Admissions/Records Unit will issue a notice of denial for applications which result in an adverse decision. This notice will include the applicant's right to an informal conference and/or a fair hearing.

3. The informal conference is a process which allows the recipient, sponsor, and/or provider the opportunity to present additional information to the Medicaid physician for a review.

4. If the review results in an adverse decision, the patient and/or sponsor will be advised of the patient's right to a fair hearing (See Chapter 3). If the reconsideration determination results in a favorable decision, the application will be processed.

(h) Authorization of level of care by nursing facility

1. The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a 10% sample of admissions and re-admissions to nursing facilities to determine the appropriateness of the admission and re-admission to the nursing facility. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

2. A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Alabama Medicaid Agency Long Term Care Admissions/Records Unit within ten working days from receipt of the certified letter shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. The Associate Director of the Long Term Care Admissions/Records Unit may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Associate Director of the Long Term Care Admissions/Records Unit with supporting documentation.

3. The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.

4. The Alabama Medicaid Agency may seek recoupment from the nursing facility for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for nursing facility care or Medicaid eligibility but for the certification of medical eligibility by the nursing facility.

Author: Marilyn F. Chappelle, Director, Long Term Care Division.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR Section 401.101-401.625, 42 CFR Section 435.900-435.1011, ,et seq.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Rule amended February 13, 1991, and August 14, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed August 21, 2006; effective December 13, 2006.

Rule No. 560-X-10-.12. Utilization Review for ICF/MR.

(1) The Utilization Review function in the ICF/MR facilities is the responsibility of Medicaid or its designee.

(a) The Utilization Review function in the ICF/MR facility will be a facility based review carried out by DMH/MR.

(b) DMH/MR will provide Medicaid with a written Utilization Review Plan. The Utilization Review Plan must include:

1. A written description of who will perform the Utilization Review.
2. At least one team member will be knowledgeable in the treatment of this type resident (Qualified Mental Retardation Professional).
3. The Utilization Review team may not include any individual who:
   (i) Is directly responsible for the care of the recipient whose case is being reviewed;
   (ii) Is employed by the ICF/MR
   (iii) Has a financial interest in any ICF/MR
4. The facility staff will provide necessary administrative support to the review team.
5. The review team will review each resident for the necessity of continued stay.
6. Certification must be made at the time of admission.
7. Recertification must be made at least every 12 months after certification in an institution for the mentally retarded or persons with related conditions.

(c) DMH/MR will provide Medicaid with a semi-annual report of utilization reviews carried out in the ICF/MR's.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; P.L. 92-603; 42 C.F.R. Section 401, et seq.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Rule amended February 13, 1991, August 14, 1991, and January 14, 1994. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.13. Resident Medical Evaluation.

(1) The admitting or attending physician must certify the necessity of admission of a resident to an intermediate care facility and make a comprehensive medical evaluation, as described in Rule No. 560-X-10-.14. This evaluation will be maintained by the facility as part of the resident's permanent record.

(2) Each Medicaid resident in an intermediate care facility must have a written medical plan of care established by his physician and periodically reviewed and evaluated by the physician and other personnel involved in the individual's care.

(3) For nursing facilities, the resident must be seen by a physician at least once every 30 days for the first 90 days from admission, and at least once every 60 days thereafter.

(4) The physician's care plan must include:

(a) Diagnosis.
(b) Symptoms and treatments.
(c) Complaints.
(d) Activities.
(e) Functional level.
(f) Dietary.
(g) Medications.
(h) Plans for continuing care and discharge as appropriate.
(i) Social services.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; P.L. 92-603; 42 C.F.R. Section 401, et seq.
History: New Rule Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.14. Resident Rights.

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, specified in 42 CFR 483.10.

(1) Exercise of rights.

(a) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(b) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising his or her rights.

(c) In the case of a resident adjudged incompetent by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

(2) Notice of rights and services.

(a) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

(b) The resident has the right to inspect and purchase photocopies of all records pertaining to the resident, upon written request and 48 hours notice to the facility.

(c) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

(d) The resident has the right to refuse treatment, and to refuse to participate in experimental research.

(e) The facility must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of:

(i) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged.

(ii) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

2. Inform each resident when changes are made to the items and services specified in paragraphs (e)1.(i) and (ii) of this section.

(f) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicaid and Medicare.

(g) The facility must furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds, under paragraph (3) of this section; and

2. A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility.

(h) The facility must inform each resident of the name, specialty and way of contacting the physician responsible for his or her care.

(i) The facility must prominently display in the facility written information, and provide to residents and potential residents oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(j) Notification of changes.

1. Except in a medical emergency or when a resident is incompetent, a facility must consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within 24 hours when there is:

(i) An accident involving the resident which results in injury.

(ii) A significant change in the resident's physical, mental, or psychosocial status.

(iii) A need to alter treatment significantly; or

(iv) A decision to transfer or discharge the resident from the facility as specified in 42 C.F.R. Section 483.12(a).

2. The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is:

(i) A change in room or roommate assignment as specified in 42 C.F.R. Section 483.15(e)(2).

(ii) A change in resident rights under Federal or State law or regulations as specified in 42 C.F.R. Section 483.10(b)(1).

3. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

(3) Protection of resident funds.

(a) The resident has the right to manage his or her financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(b) Management of personal funds. Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified below.

(c) Deposit of funds.

1. Funds in excess of $50. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's account to his or her account.

2. Funds less than $50. The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account or petty cash fund.

(d) Accounting and records. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record must be available on request to the resident or his or her legal representative.

(e) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, as specified in Section 1611(a)(3)(B) of the Social Security Act; and

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(f) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey promptly the resident's funds, and a final accounting of those funds, to the individual administering the resident's estate.

(g) Assurance of financial security. The facility must purchase a surety bond, or provide self-insurance to assure the security of all personal funds of residents deposited with the facility.

(h) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

(i) Refer to Alabama Medicaid Administrative Code, Chapter 22 for further details.

(4) Free choice. The resident has the right to:

(a) Choose a personal attending physician.

(b) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(c) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

(5) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(a) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room.

(b) The resident may approve or refuse the release of personal and clinical records to any individual outside the facility, except that the resident's right to refuse release of personal and clinical records does not apply when:

1. The resident is transferred to another health care institution; or
2. Record release is required by law or third-party payment contract.

(6) Grievances. A resident has the right to:

(a) Voice grievances with respect to treatment or care that is or fails to be furnished, without discrimination or reprisal for voicing the grievances.

(b) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(7) Examination of survey results. A resident has the right to:

(a) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The results must be posted by the facility in a place accessible to residents; and

(b) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

(8) Work. The resident has the right to:

(a) Refuse to perform services for the facility.

(b) Perform services for the facility, if he or she chooses, when:

1. The facility has documented the need or desire for work in the plan of care;
2. The plan specifies the nature of the services performed and whether the services are voluntary or paid;
3. Compensation for paid services is at or above prevailing rates; and
4. The resident agrees to the work arrangement described in the plan of care.

(9) Mail. The resident has the right to privacy in written communications, including the right to:

(a) Send and receive mail promptly that is unopened; and

(b) Have access to stationery, postage and writing implements at the resident's own expense.

(10) Access and Visitation Rights.

(a) The resident has the right and the facility must provide immediate access to any resident by the following:

1. Any representative of the Department of Health and Human Services.
2. Any representative of the State.
3. The resident's individual physician.

4. The State long term care ombudsman (established under _307(a)(12) of the Older Americans Act of 1965).

5. The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act).

6. The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act).

7. Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

8. Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(b) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(c) The facility must allow representatives of the State Long Term Care Ombudsman, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.

(11) Telephone. The resident has the right to have regular access to the private use of a telephone.

(12) Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(13) Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

(14) Self-Administration of Drugs. Each resident has the right to self-administer drugs unless the interdisciplinary team, as defined by 42 C.F.R. Section 483.20(d)(2)(ii), has determined for each resident that this practice is unsafe.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 442.311(A)-4 Section 405.1121 (K)-2 and Section 483.10. Omnibus Budget Reconciliation Act of 1987.
History: Rule effective October 1, 1982. Amended October 7, 1983; February 8, 1984; October 9, 1985; and May 10, 1988. Emergency rule effective January 1, 1990. Amended April 17, 1990. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.15. Nursing Aide Training.

(1) A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide in the facility on or after October 1, 1990, for more than four (4) months unless the individual has completed a training and competency evaluation program, or a competency evaluation program, approved by the State and is competent to provide nursing or nursing related services.

(2) The Alabama Department of Public Health will be responsible for the certification of the Competency Evaluation programs and will establish and maintain a nurse aide registry.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq., Section 431, and Section 483. OBRA-87 Sections 4201(a) and 4211(a); OBRA-89 Section 6901(b).

History: Rule effective October 1, 1982. Amended September 8, 1983. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.16. Preadmission Screening and Resident Review.

(1) Prior to admission, all individuals seeking admission into a nursing facility must be screened for suspected mental illness (MI), intellectual disability (ID), or a related condition (RC) to determine if the individual's care and treatment needs can most appropriately be met in the nursing facility or in some other setting.

(2) A Level I screening document (LTC-14) must be completed in its entirety and submitted to OBRA PASRR Office for a Level I Determination prior to admission. The Level I Screening can be completed by anyone who has access to the medical records excluding family members.

(3) The nursing facility is responsible for ensuring that the applicant is not admitted into the nursing facility without a Level I Screening, Level I Determination and Level II Determination, if applicable, from the Department of Mental Health. The nursing facility is responsible for ensuring that the Level I Determination is signed and dated by the RN indicating that the Level I Screening is accurate based on the available medical records.

(4) The Department of Mental Health is responsible for conducting a Level II Evaluation on all applicants and residents with a suspected diagnosis of MI/ID/RC to determine the individual's need for mental health specialized services and medical eligibility. For all residents with a primary or secondary diagnosis of MI/ID, the Department of Mental Health will make the determination of appropriate placement in a nursing facility, based on the results of the Level II Screening and the application of Medicaid medical criteria.

(5) If the nursing facility fails to obtain the Level I screening, Level I Determination and Level II Determination, if applicable, made by the Department of Mental Health prior to admitting the resident into their facility, the Alabama Medicaid Agency will recoup all Medicaid payments for nursing facility services from the date of the resident's admission and continuing until the Level I Determination or Level II Determination, if applicable, is received.

(6) If a resident is discharged into the community for more than 30 days, a new Level I Screening, Level I Determination, and Level II Determination, if applicable, is required before admission.

(7) If the nursing facility's interdisciplinary team identifies a significant change in the condition of a resident with a diagnosis of MI/ID/RC, an updated Level I Screening must be completed and submitted to the Department of Mental Health's PASRR Office within 14 days of the resident's status change to receive an updated Level II Determination to establish continued eligibility. If the nursing facility fails to update the Level I Screening for a significant change in a resident's condition, the Alabama Medicaid Agency may recoup all Medicaid payments for nursing facility services from 14 days of the resident's change in condition and continuing until the updated Level II Determination is received.

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 435.911.
History: Rule effective October 1, 1982. Amended February 8, 1984; October 9, 1985 and December 12, 1988. Emergency rule effective January 1, 1989. Amended April 14, 1989. Emergency rule effective June 1, 1989, and October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed September 21, 2009; effective December 23, 2009.

Rule No. 560-X-10-.17. Medical Director.

(1) The nursing facility shall retain, pursuant to a written agreement, a physician licensed under state law to practice medicine or osteopathy, to serve as medical director on a part-time or full time basis as is appropriate for the needs of the residents and the facility.

(a) If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the governing body.

(b) A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, a hospital medical staff, or through another similar arrangement.

(2) The medical director is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents and to maintain surveillance of the health status of employees.

(a) The medical director is responsible for the development of written bylaws, rules, and regulations which are approved by the governing body and include delineation of the responsibilities of attending physicians.

(b) Coordination of medical care includes liaison with attending physicians to ensure their writing orders promptly upon admission of a patient, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.

(c) The medical director is also responsible for surveillance of the health status of the facility's employees, and reviews incidents and accidents that occur on the premises to identify hazards to health and safety. The administrator is given appropriate information, by the medical director, to help ensure a safe and sanitary environment for residents and personnel.

(d) The medical director is responsible for the execution of resident care policies.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq., Section 405.1122, and Section 405.307, et seq.
History: Rule effective October 1, 1982. Amended February 8, 1984 and October 13, 1987. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.18. Availability of Nursing Facilities Accounting Records.

(1) Availability of accounting records must be made available in compliance with chapter 22, Alabama Medicaid Administrative Code.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 483.10. Omnibus Budget Reconciliation Act of 1987.
History: Rule effective October 1, 1982. Amended November 10, 1983; December 18, 1986; and September 13, 1989. Emergency rule effective October 1, 1990. Amended February 13, 1991.
Amended: Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.19. Administration of Medication.

(1) The facility must provide routine and emergency drugs and biologicals to its residents.

(2) Alabama law prohibits nonlicensed personnel from administering medication.

(3) A facility must permit residents to self-administer a drug when the facility determines, in accordance with the comprehensive assessment, that a resident is a good candidate, when the resident demonstrates that he or she can securely store, safely administer and accurately record the administration of drugs, and the facility reassesses the residents ability to self-administer drugs at least every three months.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 483.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.20. Conditions Under Which Nursing Facilities are Not Classified as Mental Disease Facility Under Title XIX.

(1) Nursing facilities located on grounds of State Mental Hospitals or in the communities, must follow the required criteria to meet specific conditions in order to be eligible for Federal matching funds for care provided to all individuals eligible under the State Plan.

(2) The Alabama Medicaid Agency is responsible for coordinating with the proper agencies concerning the mental disease classification of nursing facilities. Facilities are NOT considered institutions for mental disease if they meet the following criteria:

(a) The facility is established under State law as a separate institution organized to provide general medical care and does offer and provide such care.

(b) The facility is licensed separately under a State law governing licensing of medical institutions other than mental institutions.

(c) The facility is operated under standards which meet those for nursing facilities established by the responsible State authority.

(d) The facility is operated under policies which are clearly distinct and different from those of the mental institutions and which require admission of patients from the community who need the care it provides.

(e) The facility is dual certified under Title XVIII and XIX.

(f) The facility is not maintained primarily for the care and treatment of individuals with mental disease.

(3) If the facility under examination meets one of the following criteria, it is deemed to be maintained primarily for the care and treatment of individuals with mental disease:

(a) It is licensed as a mental institution;

(b) It is advertised as a mental institution;

(c) More than fifty percent (50%) of the patients are receiving care because of disability in functioning resulting from a mental disease. Mental diseases are those listed under the heading of Mental Disease in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, International Classification of Diseases, adopted for use in the United States (ICD-9 or its successors), except for mental retardation.

(4) Mental illness definition: An individual is considered to have mental illness if he or she has a current primary or secondary diagnosis of a major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or its successors), and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and 483.
History: Rule effective October 1, 1982. Emergency rule effective January 1, 1989 and February 1, 1989. Amended April 14, 1989 and May 12, 1989. Emergency rule effective January 1, 1990. Amended April 17, 1990. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.21. Admission of Mentally Ill Residents to Nursing Facilities.

(1) Nursing facilities must monitor the admission of mental residents to their facilities.

(a) A nursing facility may not have more than fifty percent (50%) mental residents which is based on the total population of the facility including public and private pay residents.

(b) If a facility does have more than fifty percent (50%) mental residents, it will be designated as an institution for mental diseases for Medicaid payment purposes.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. 401, et seq. and Section 483.
History: Emergency rule July 1, 1988. Amended July 12, 1988 and January 10, 1989. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.22. Quality of Life.

(1) A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. Factors to be considered include:

(a) Dignity
(b) Self determination and participation
(c) Participation in resident and family groups.
(d) Participation in other Activities
(e) Accommodation of needs
(f) Activities
(g) Social Services
(h) Environment

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 483.15. Omnibus Budget Reconciliation Act of 1987.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.23. Resident Assessment.

(1) The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required by 42 C.F.R. Section 483.20 and any other applicable State and Federal requirements.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 483.20. Omnibus Budget Reconciliation Act of 1987.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.24. Quality of Care.

(1) Each resident must receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and plan of care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 483.25. Omnibus Budget Reconciliation Act of 1987.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.25. Resident Behavior and Facility Practices

(1) The resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

(2) The resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion.

(3) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act; Omnibus Budget Reconciliation Act of 1987. 42 C.F.R. Section 401, et seq. and Section 483.13.
History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.26. Transfer and Discharge Rights.

(1) Definitions.

(a) Discharge means movement from an entity that participates in Medicare as a skilled nursing facility (SNF), a Medicare certified distinct part, an entity that participates in Medicaid as a nursing facility (NF), or a Medicaid certified distinct part to a noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident.

(b) Resident means a resident of a SNF or NF or any legal representative of the resident.

(c) Transfer means movement from an entity that participates in Medicare as a SNF, a Medicare certified distinct part, an entity that participates in Medicaid as a NF or a Medicaid certified distinct part to another institutional setting when the legal responsibility for the care of the resident changes from the transferring facility to the receiving facility.

(2) Transfer and Discharge Requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(b) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(c) The safety of individuals in the facility is endangered;

(d) The health of individuals in the facility would otherwise be endangered;

(e) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(f) The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified above, the resident's clinical record must be documented. The documentation must be made by:

(a) The resident's physician when transfer or discharge is necessary under paragraph (2)(a) or (2)(b) of this rule; and

(b) A physician when transfer or discharge is necessary under paragraph (2)(d) of this rule.

(4) Notice Before Transfer. Before a facility transfers or discharges a resident, the facility must:

(a) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons;

(b) Record the reasons in the resident's clinical record; and

(c) Include in the notice the items described in paragraph (6) of this rule.

(5) Timing of the Notice.

(a) Except when specified in paragraph (5)(b) of this rule, the notice of transfer or discharge required under this rule must be made by the facility at least 30 days before the resident is transferred or discharged.

(b) Notice may be made as soon as practicable before transfer or discharge when:

1. The safety of individuals in the facility would be endangered;
2. The health of individuals in the facility would be endangered;
3. The resident's health improves sufficiently to allow a more immediate transfer or discharge;
4. An immediate transfer or discharge is required by the resident's urgent medical needs; or
5. A resident has not resided in the facility for 30 days.

(6) Contents of the Notice. For nursing facilities, the written notice specified in paragraph (4) of this rule must include the following:

(a) The reason for transfer or discharge;

(b) The effective date of transfer or discharge;

(c) The location to which the resident is transferred or discharged.

(d) The name and address of the Alabama Medicaid Agency and a statement that the resident has the right to appeal the action to the Medicaid Agency by filing a written request within 30 days of the notice of transfer or discharge;

(e) The name, address and telephone number of the State long term care ombudsman;

(f) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(g) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(7) Orientation for Transfer or Discharge.

(a) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(b) The resident's clinical record must be documented when the facility transfers or discharges a resident. The documentation should include a statement from the resident's physician indicating that the resident may be transferred or discharged including the level of care required for the resident.

(8) Appeal of Transfer or Discharge.

(a) A resident who is aggrieved by a facility's decision to transfer or discharge the resident may request a review of the decision by the Medicaid Agency. Such request must be in writing and received within 30 days of the date of the notice of transfer or discharge.

(b) Upon receipt of a request for review, Medicaid will promptly notify the facility and the resident of the procedures to be followed. Once the resident has requested a review of the discharge, the nursing facility must allow the resident to remain in the facility until all administrative appeals have been exhausted unless there is documented verifiable evidence in the resident's medical record indicating that the facility can no longer meet the resident's needs or he is a danger to the health and safety of other resident's in the facility and an appropriate placement for the resident has been located. Both parties will be allowed 10 days to submit any documentary information regarding the proposed transfer or discharge. If deemed desirable, Medicaid may contact one or both parties to obtain additional information, either written or oral. Properly qualified personnel will be utilized in the review process, and all decisions involving medical issues will be made by a Medicaid physician.

(c) Both parties will be notified by certified mail of the review decision. An aggrieved party may request a fair hearing by filing a written request with Medicaid within 30 days of the date of the review decision letter. Except as otherwise provided herein, hearings will be conducted in accordance with Chapter 3 of this Administrative Code. The hearing will be a de novo proceeding to review the decision to transfer or discharge. Both the facility and the resident will be notified of the hearing date and will be entitled to participate. The hearing decision will be binding on all parties, regardless of whether a party participates in the fair hearing.

(9) 24 hour hospital stay. Resident's of nursing facilities who go to a hospital to receive outpatient services, i.e. emergency room observation, etc., do not have to be discharged from the nursing facility unless the resident is retained longer than 24 hours. After 24 hours discharge by the nursing facility is necessary. Residents who go to a hospital to receive inpatient service must be discharged. If an inpatient claim suspends as a duplicate of a nursing facility claim, the inpatient claim shall be paid and the other claim shall be denied or recouped unless the "from" and "to" dates on the hospital claim are the same. It is the nursing facilities responsibility to monitor the status of residents in hospitals to assure that discharge and readmissions to the nursing facility are properly reported.

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan Attachment 4.35-B; Title XIX, Social Security Act, Sections 1819 and 1919; 42 CFR 431.200 et seq., and 483.200 et seq.
History: Rule effective January 8, 1985. Emergency rule effective October 1, 1990. Amended February 13, 1991, and August 12, 1993. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed March 20, 2008; effective June 18, 2008.

Rule No. 560-X-10-.27. Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

The regulations of the Centers for Medicare and Medicaid Services, Department of Health and Human Services at 42 C.F.R. Section 488.400, et seq., as promulgated in 59 Federal Register 56116 (Nov. 10, 1994), and as may be subsequently amended, are adopted by reference. Copies of these regulations may be obtained from the U.S. Government Printing Office, Washington, DC 20402-9328. Copies are also available from Medicaid at a cost of $2.50.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act, Section 1919; 42 C.F.R. Section 442.1, et seq., Section 431.151, et seq., Sections 441.11 and 489.53; Ala. Code (1975) Section 22-6-20, et seq. Section 488.400, et seq., and 498.1, et seq.
History; Rule effective October 1, 1982. Emergency Rule effective July 22, 1988. Amended October 12, 1988. Emergency rule effective October 1, 1990. Amended February 13, 1991. Emergency Rule Effective July 1, 1995. Amended August 12, 1995. **Amended:** Filed June 20, 2003; September 15, 2003.

Rule No. 560-X-10-.28. Financial Eligibility.

(1) Financial eligibility will be established in accordance with Chapter 25, Alabama Medicaid Administrative Code.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; Title XIX, Social Security Act.
History: Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.29. Claim Filing Limitations.

(1) For claim filing limitations refer to Alabama Medicaid Administrative Code, Rule No. 560-X-1-.17.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan, Title XIX, Social Security Act; 42 C.F.R. Section 447.45, et seq.
History: Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule 560-X-10-.30. Third Party Payment Procedures.

(1) Refer to Alabama Medicaid Administrative Code, Chapter 20.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan, Title XIX, Social Security Act; 42 C.F.R. Sections 433.135, 433.138 and 433.139.
History: Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Chapter 11. Early and Periodic Screening, Diagnosis, and Treatment for Individuals Under Twenty-one (21)

Rule No. 560-X-11-.01. Early and Periodic Screening, Diagnosis, and Treatment for Individuals Under Twenty-one (21) - General.

(1) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of certain eligible individuals under age twenty-one (21) is a mandatory service of the Medicaid Program intended by Congress to direct attention to the importance of preventive health services and early detection and treatment of disease in children eligible for medical assistance.

(2) The Alabama Medicaid Agency:

(a) Will provide for a combination of written and oral methods designed to effectively inform all EPSDT eligible individuals (or their families) about the EPSDT program. Generally, this information will be provided within 60 days of the individual's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter.

(b) Will using clear and nontechnical language, provide information about the following: the benefits of preventive health care, the services available under the EPSDT program, and how to obtain these services.

(c) Will inform recipients that the services provided under the EPSDT program are without cost to eligible individuals under 21 years of age. Exception: Copayment is required of individuals from eighteen (18) to under twenty-one (21).

(d) Will provide other medically necessary health care, diagnostic, treatment and/or other measures described in section 1905(a) of Title XIX to correct or ameliorate defects, physical and mental illnesses and conditions discovered during a screening.

(e) Will inform individuals that necessary transportation and scheduling assistance are available upon request.

(f) Will provide an extensive outreach program for EPSDT recipients.

(g) In conjunction with the Alabama Department of Human Resources, will jointly develop an agreement covering the responsibilities of the county Departments of Human Resources, county Health Departments and other screening providers for EPSDT.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56; OBRA '89-Section 6403. Rule effective October 1, 1982. Rule amended June 8, 1985. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Amended February 13, 1991. ER effective December 1, 1992. Effective date of this amendment January 13, 1993.

Rule No. 560-X-11-.02. Major Components of EPSDT.

(1) Early

As early as possible in the life of a child already Medicaid eligible or as soon as possible after a person's eligibility is established, if he or she is under twenty-one (21) years of age;

(2) Periodic

At intervals established by Medicaid to assure that disease or disability is not incipient or present in persons eligible for the EPSDT services;

(3) Screening

Assessment of the physical and mental health of all persons under twenty-one (21) years of age who are Medicaid eligible.

(4) Diagnosis

Further study of persons to determine the nature or cause of disease or abnormality to provide a frame of reference for treatment;

(5) Treatment

Any Treatment available under the Alabama Medicaid Program including eyeglasses, hearing aids and other necessary health care, diagnostic services to correct or ameliorate defects, physical and mental illnesses and conditions discovered during a screening.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.50; OBRA '89-Section 6403. Rule effective October 1, 1982. Rule amended June 8, 1985. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.03. Eligibility.

(1) All persons under twenty-one (21) years of age except SOBRA adult eligibles who have been certified as being eligible for Medicaid are eligible for the EPSDT program.

(2) Alabama Medicaid Agency assigns Medicaid identification numbers and issues plastic Medicaid eligibility cards to persons eligible for benefits.

(3) In providing services and filing a claim for medical payment, it is required that a person be eligible in the month in which the service is rendered.

(4) Alabama Medicaid Agency Administrative Code, Chapter One, General, contains information about the identification of Medicaid recipients.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.50; OBRA '89-Section 6403. Rule effective October 1, 1982. Rule amended June 8, 1985. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Amended February 13, 1991. ER effective December 1, 1992. Effective date of this amendment January 13, 1993.

Rule No. 560-X-11-.04. EPSDT Manual.

(1) A manual on the EPSDT Program setting forth in detail the elements of the physical examination, instructions for completion of forms, processes and procedures to follow in administration of local programs and billing instructions will be provided to each EPSDT provider. Failure to follow the procedures and requirements as outlined in the manual may result in recoupment of the funds paid to the provider.

(2) EPSDT School-Based screening providers must follow the Protocols and Procedures for EPSDT School-Based services in addition to the EPSDT Manual. Failure to comply may result in recoupment of the funds paid to the provider.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56(d). Rule effective October 1, 1982. ER effective December 1, 1986. Amended March 12, 1987. ER effective October 1, 1990. Amended February 13, 1991. Effective date of this amendment May 11, 1995.

Rule No. 560-X-11-.05. Providers of Screening Services.

(1) In-state and borderline out-of-state (within 30-mile radius of state line) health care agencies and physicians wishing to participate in the EPSDT Program may request enrollment information from the Alabama Medicaid Agency. Exception: The Fiscal Agent will be responsible for enrolling any Title XVIII (Medicare) providers that wish to enroll as a QMB-only provider.

(2) All providers of screening services must enter into an agreement with Alabama Medicaid Agency to participate in the EPSDT Program as a screening provider. Exception: QMB-only providers. Each off-site location will require a separate application, a separate contract, and will be assigned a provider number distinct from any other the provider may have with Medicaid.

(3) All health care agencies enrolled shall be under the direction of a duly-licensed physician, a currently licensed registered nurse, or a certified nurse practitioner who shall be responsible for assuring that requirements of participation are met and that the procedures established by the Medicaid program are carried out.

(4) Screening programs conducted under the direction of a registered nurse or certified nurse practitioner must have a licensed physician acting as medical consultant.

(5) EPSDT services may be offered by School-Based screening providers.

Author: Lynn Sharp, Associate Director, Policy Development, Medical Services Division
Statutory Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 400.203, Section 441.56. Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360). OBRA '89-Section 6403.
History: Rule effective October 1, 1982, May 9, 1984, July 9, 1984, December 1, 1986, March 12, 1987, July 13, 1989, October 1, 1990, February 13, 1991, May 11, 1995. Amended: Filed February 19, 1999; effective May 10, 1999.

Rule No. 560-X-11-.06. Procedures and Tests in the Screening Examination.

(1) The Agency will establish specific health evaluation procedures to be used by screening providers. These procedures and tests will be fully described in the Screening Provider Manual.

(2) All procedures and tests included in the Screening Provider Manual must be carried out on each person screened and must be recorded in the case history of the individual.

(3) Where it is not possible to carry out all procedures and tests, this fact must be recorded in the case history of the individual, including the reason such procedure or test was not carried out.

(4) Requirements in this paragraph are subject to federal and state audits and documentation in the records will be examined in on-site visits from time to time. Failure to meet these requirements may result in recoupment of the funds paid to the provider.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56(d); OBRA '89-Section 6403. Rule effective October 1, 1982. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.07. Screening Schedule.

(1) The Agency will establish a distinct periodicity schedule for screening services, after consultation with recognized medical organizations involved in child health care. This schedule will be published in the Screening Provider Manual.

(2) Periodic screening services will be provided at intervals that meet reasonable standards of medical practice in accordance with those described for well-child care in the Guidelines for Health Supervision of American Academy of Pediatrics.

(3) Interperiodic screenings are covered when medically necessary to determine the existence of suspected physical or mental illnesses or conditions.

(4) An EPSDT Intensive Developmental Diagnostic Assessment is a multidisciplinary comprehensive screening limited to infants 0 to under two years of age, and is also limited to two per recipient per lifetime. These screenings are in addition to the routine periodic screenings and must be performed by a qualified EPSDT Intensive Developmental Diagnostic Assessment Screening provider, as approved and enrolled by Medicaid.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.50; OBRA '89-Section 6403. Rule effective October 1, 1982. Amended July 9, 1984, June 8, 1985. ER effective October 1, 1986. Amended October 11, 1986. ER effective December 1, 1986. Amended March 12, 1987. ER effective November 7, 1988. Emergency Rule effective October 1, 1989. ER effective October 1, 1990. Amended February 13, 1991. Effective date of this amendment January 13, 1993.

Rule No. 560-X-11-.08. Consultation Services to Screening Providers.

(1) Professional nursing staff of the Alabama Medicaid Agency will provide assistance to any screening provider who requests it.

(2) The Medicaid staff will assist providers and County Departments of Human Resources with problems in local administration of the EPSDT Program upon request, or as need is identified in on-site visits to screening providers.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.61. Rule effective October 1, 1982. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.09. EPSDT Referral for Services.

(1) All participating EPSDT providers will complete the EPSDT Referral for Services form for each individual provider to whom a person is being referred to for further diagnosis and/or treatment.

(2) When a screening provider refers a person to a Medicaid participating provider for diagnosis and/or treatment, all treatment services will be considered for reimbursement, above current limitations. However, the services rendered must be medically necessary to treat or ameliorate a condition or diagnosis identified in a screen.

(3) The referring provider must document within the patient's medical history or physical examination portion of the medical record the condition(s) identified during an EPSDT Screening examination which requires a referral. Notation of the condition on the EPSDT referral form alone will not be considered sufficient documentation. Medicaid has the right to recoup payment for the screening service from the referring provider, when a referral is made for a condition not documented in the medical history or physical examination portion of the medical record.

(4) Alabama Medicaid Agency Administrative Code, Chapter One, General, contains information about extended benefits as a result of an EPSDT screening and referral.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.61; OBRA '89-Section 6403. Rule effective October 1, 1982. Emergency Rule effective December 1, 1986. Amended March 12, 1987. Emergency Rule effective October 1, 1990. Amended February 13, 1991. Effective date of this amendment July 11, 1995.

Rule No. 560-X-11-.10. Reimbursement.

(1) Governmental screening providers (including physicians) will be paid on a negotiated rate basis which will not exceed their actual costs. Non-governmental screening providers will be paid their usual and customary charge which is not to exceed the maximum allowable rate established by Medicaid.

(2) In screening a recipient, the provider's contract screening cost will cover the following services: unclothed physical examination; vital signs; height~~s~~ and weight~~s~~; family, medical, mental health and immunization histories, vision and hearing testing; developmental assessment including anticipatory guidance and nutritional assessment; hematocrits or hemoglobins; and follow-up of all referred conditions to ensure whether or not treatment has been initiated.

(3) Providers may submit claims for immunization, TB skin test and treatment on the day of screening. These charges submitted on the CMS 1500 form are in addition to the screening charge, but no office visit should be charged at that time.

Author: Kaye Melnick, EPSDT Program Manager, Medical Support Programs
Statutory Authority: Title XIX, Social Security Act; State Plan attachment 3.1-A; 42 CFR Section 441.50; OBRA '89-Section 6403.
History: Rule effective October 1, 1982, July 9, 1984, December 1, 1986, March 12, 1987, October 1, 1990, February 13, 1991. **Amended:** Filed April 20, 2009; effective July 16, 2009.

Rule No. 560-X-11-.11. Consent for Health Services for Certain Minors and Others.

(1) Consent for health services for certain minors, and others will be governed by Code of Alabama, 1975, Title 22, Chapter 8.

(2) All consent forms must be signed by the parent or legal guardian except for clients fourteen (14) years and older who may sign for themselves.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56. Code of Alabama, 1975. Rule effective October 1, 1982. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.12. Notification Procedures for Handicapped Individuals Eligible for EPSDT.

(1) Hearing Impaired:

(a) Each recipient will be notified of services during a face-to-face verbal interview at which time an individual who communicates via sign language or other methods will be present if needed to pass information to the recipient.

(b) Written information will to be given to both the recipient and the individual who communicates with him.

(2) Visually Impaired:

(a) Each recipient will be notified of services during a face-to-face interview, during which time an individual who can communicate with the recipient will be present, if needed, to pass information to him.

(b) The recipient will be given information in Braille. Written information will be given to the individual who communicates with the recipient as well.

(3) Those Who Do Not Speak English:

(a) Each recipient will be notified of services during a face-to-face interview at which time an individual who communicates in the recipient's language will be present for interpretation.

(b) Written materials in Thai, Laotian, Cambodian, and Vietnamese languages are available and will given to recipients who speak these languages and may also be given to the interpreter for those who are illiterate.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.56. Rule effective October 1, 1982. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.13. State Laboratory Services.

(1) Arrangements have been made with the Clinical Laboratory Administration to have the State Laboratory examine blood specimens for sickle cell anemia and other abnormal hemoglobins, stool specimens for ova and parasites, and scotch tape preparations for pinworms. VDRL, G.C. cultures, throat culture and blood lead level may also be done at no cost to the provider.

(2) Payment is made by Medicaid to the laboratories who have been enrolled as Medicaid providers for examination of specimens submitted by screening agencies and physicians.

(3) Care should be taken to see that the correct Medicaid number is entered on the label or form accompanying such specimens.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 441.61; OBRA '89-Section 6403. Rule effective October 1, 1982. ER effective December 1, 1986. Effective date of this amendment March 12, 1987. ER effective October 1, 1990. Effective date of this amendment February 13, 1991.

Rule No. 560-X-11-.14 EPSDT Referred Service Providers

(1) OBRA '89 requires that medically necessary health care, diagnosis, treatment and/or other measures described in Section 1905(a) of the Social Security Act be covered under Medicaid if identified in an EPSDT screening whether or not such services are covered in the State Plan. If services are not ordinarily provided as a Medicaid benefit for children under age 21, the providers of the service will be enrolled to provide "EPSDT only" referred care. An EPSDT referral form must be maintained by the provider for services provided as a result of a screening.

(a) EPSDT-only providers include: physical therapists, occupational therapists, speech therapists, chiropractors, podiatrists, psychologists, private duty nurses, air transportation, and environmental lead investigators.

(b) Enrollment: Instate and borderline out-of-state (within 30 mile radius of the Alabama state line) are eligible to enroll as EPSDT-only providers.

(c) Documentation: EPSDT-only services are covered by Alabama Medicaid when medically necessary and when done to correct or ameliorate a defect, physical or mental illness or other conditions identified during an EPSDT Screening Exam. EPSDT-only providers must develop a plan of treatment and have it readily available at all times for review in the recipient's medical record. The plan of treatment should contain but is not limited to the following information:

1. Recipient's name,
2. Recipient's current Medicaid number,
3. Date of EPSDT Screening,
4. Referring physician's name,
5. Diagnosis(es),
6. Date of onset or acute exacerbation, if applicable,
7. Type of surgery performed, if applicable,
8. Date of surgery, if applicable,
9. Functional status prior to treatment and expected status after treatment, if applicable,
10. Frequency and duration of treatment, if applicable,
11. Modalities, if applicable, and
12. For ulcers, the location, size and depth should be documented, if applicable.

(d) Retrospective Review: Medicaid's Surveillance and Utilization Review Program

will review medical records retrospectively to determine the appropriateness of the service rendered. Medicaid may discontinue and/or recoup payment for the treatment or service if any of the following circumstances have occurred:

1. An EPSDT screening was not performed,
2. The condition/diagnosis noted on the EPSDT referral form does not relate to the treatment performed, and
3. The EPSDT screening form is not valid. (EPSDT screening referral forms are valid only for the time specified by the referring provider or up to a maximum of twelve (12) months).

(2) Qualifications For EPSDT-only Providers:

(a) Physical Therapists (PT) - A qualified PT must be licensed by the Alabama Board of Physical Therapy. Services provided must be ordered by a physician for an identified condition(s) noted during the EPSDT screening exam and provided by or under the supervision of a qualified physical therapist. Group physical therapy is covered only for codes specified as such in the Physical Therapy Billing Manual. Only procedure codes identified in the Medicaid Physical Therapy Billing Manual are reimbursable. Some codes may require attainment of prior authorization before services are rendered. Recreational and leisure type activities such as movies, bowling, skating, etc. are not covered by Medicaid.

1. Physical therapy may be provided by a PT assistant who practices under the direction of a licensed PT. Assistants may perform treatment procedures as delegated by the PT but may not initiate or alter a treatment plan. PT assistants must be licensed by the Alabama Board of Physical Therapy and must be an employee of the supervising PT in order for the PT to bill for services. The PT must oversee the assistants' activities on a frequent, regularly scheduled basis. Scheduled visits to supervise care provided by the assistant must be documented and signed by the PT at a minimum every 6th visit.
2. Physical therapy aides who are employed by the PT may perform only routine treatment procedures as allowed by State law and only under direct, on-site supervision of the licensed PT. Care rendered by a PT aide shall not be held out as and shall not be charged as physical therapy.

(b) Occupational Therapists (OT) - A qualified OT must be licensed by the Alabama State Board of Occupational Therapy. Services provided must be ordered by a physician for an identified condition(s) noted during the EPSDT screening exam and provided by or under the direct supervision of a qualified occupational therapist. Group occupational therapy is covered only for codes specified as such in the Occupational Therapy Billing Manual. Services are limited to those procedures identified in the Occupational Therapy Billing Manual. Some codes may require attainment of prior authorization before services are rendered. Recreational and leisure type activities such as movies, bowling, skating, etc. are not covered by Medicaid.

1. OT assistants are allowed to assist in the practice of occupational therapy only under the supervision of an OT. OT assistants must have an Associate of Arts degree and must be licensed by the Alabama State Board of Occupational Therapy. Supervision of certified OT assistants must consist of a minimum of one on one on-site supervision at least eight hours per month. Supervision for non certified limited permit holders shall consist of one to one, on-site supervision a minimum of 50% of direct patient time by an OT who holds a current license. Supervising visits must be documented and signed by the OT. The supervising OT must ensure that the assistant is assigned only duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.
2. OT aides employed by the OT are allowed to perform only routine duties under the direct, on-site supervision of the OT. Care rendered by an OT aide shall not be held out as and shall not be charged as occupational therapy.

(c) Speech Therapists (ST-Speech Language Pathologist) - A qualified ST must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology and Audiology. Services provided must be ordered by a physician for an identified condition(s) noted during the EPSDT Screening exam and provided by or under the supervision of a qualified speech therapist. Only procedures identified in the Medicaid Speech Therapy Billing Manual are reimbursable.

1. Speech Therapy Assistants must be employed by a Speech Therapist, have a bachelor degree in Speech Pathology and must be registered by the Alabama Board of Speech, Language Pathology and Audiology. Assistants are allowed to provide services commensurate with their education, training and experience only. They may not evaluate speech, language or hearing, interpret measurements of speech language or hearing, make recommendations regarding programming and hearing aid selection, counsel patients or sign test reports, nor other documentation regarding the practice of speech pathology. Assistants must work under the direct supervision of a licensed speech pathologist. Direct supervision requires the physical presence of the licensed speech pathologist in the same facility at all times when the assistant is performing assigned clinical responsibilities. The licensed speech pathologist must document direct observation of at least ten (10%) percent of all clinical services provided by the assistant. Speech therapists may supervise no more than the equivalent of two full-time assistants concurrently.

(d) Services provided under the direction of a health care practitioner provided to Medicaid eligible children by those working under the direction of licensed, enrolled Speech Therapists, Occupational Therapists or Physical Therapists as provided for in this rule must be provided under the following conditions:

1. The person providing the service must meet the minimum qualifications established by State laws and the Agency regulations and be in the employment of the supervising provider;

2. The person providing the service must be identifiable in the case record;

3. The supervising therapist must assume full professional responsibility for services provided and bill for such services;

4. The supervising provider must assure that services are medically necessary and rendered in a medically appropriate manner, and

(e) Podiatrist - Must have a current licensed issued to practice podiatry, and operate within the scope of practice established by the appropriate state's Board of Podiatry.

(f) Chiropractor - Must have a current certification and/or be licensed to practice chiropractic, and operate within the scope of practice established by the state's Board of Chiropractic Examiners.

(g) Psychologist - Must have a doctoral degree from an accredited school or department of Psychology and have a current license to practice as a psychologist, and operate within the scope of practice as established by the appropriate state's Board of Psychology.

1. Minimum Qualifications for Psychology Providers'

Professional Staff working under Medicaid-enrolled Psychologists are as follows:

(i) A professional counselor licensed under Alabama law (e.g. LPC, ALC),

(ii) A marriage and family therapist licensed under Alabama law,

(iii) A certified social worker licensed under Alabama law,

(iv) A licensed psychological technician,

(v) An individual possessing a masters degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling, behavioral specialist, or other areas that require equivalent clinical course work and who meets at least one of the following qualifications.

(I) Has successfully completed a practicum as a part of the requirements for the degree or,

(II) Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of post graduate clinical experience.

2. Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the service descriptions.

(h) Private Duty Nursing – The purpose of the Private Duty Nursing Program is to provide payment for quality, safe, cost-efficient skilled nursing care to Medicaid recipients who require a minimum of four consecutive hours of continuous skilled nursing care per day. Skilled nursing care is

defined as prescribed care that can only be provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) which is medically necessary to treat or ameliorate medical conditions identified as a result of an EPSDT screening. The medical criteria herein must be present when the specified condition listed below is found. For conditions not found in the Alabama Medicaid Administrative Code, medical necessity review will be conducted by the Medicaid Medical Director. Medicaid recipients who do not meet the medical necessity requirements for the Private Duty Nursing Program have access to a variety of nursing and related community services. The Agency will make referrals to the appropriate programs based on the level of care needed.

1. **Criteria – Non-ventilator Dependent Recipients**.

(i) High technology non-ventilator dependent recipients may qualify for private duty nursing services if they meet either of the following criteria and at least one qualified caregiver has been identified:

(I) Any one of the primary requisites are present.

(II) Two or more secondary requisites are present.

(ii) *Primary Requisites* – include, but may not be limited to, the following as qualifying criteria for nursing recipients:

(I) Tracheotomy – Coverage up to four months for acute (new) tracheotomy and up to an additional two months with documentation of continuing acute problems. Continuation of nursing services may be approved after initial certification for those periods of time when the primary caregiver is away from the home for work or school or otherwise unable to provide the necessary care.

(II) Total Parenteral Nutrition (TPN) – Coverage up to two months for acute phase with additional certification based upon the need for continuing therapy.

(III) Intravenous Therapy – Coverage up to two months for a single episode. The number of hours required for a single infusion must be at least four continuous hours and require monitoring and treatment by a skilled nurse. An additional period of certification may be approved based on medical necessity for continuing therapy. Additional hours may also be approved for secondary criteria requisites listed below in conjunction with the primary criteria requisites.

(iii) *Secondary Requisites* – include, but may not be limited to, the following as qualifying criteria for nursing recipients.

(I) Decubitus ulcers – Coverage for stage three or four ulcers.

(II) Colostomy or ileostomy care – Coverage for new or problematic cases.

(III) Suprapubic catheter care – Coverage for new or problematic cases.

(IV) Internal nasogastric or gastrostomy feedings – Coverage for new or problematic cases.

(iv) *Qualified Caregiver*.

(I) The family must have at least one member capable of and willing to be trained to assist in the provision of care for the recipient in the home.

(II) The family must provide evidence of parental or family involvement and an appropriate home situation (for example, a physical environment and geographic location for the recipient's medical safety).

(III) Reasonable plans for emergencies (such as power and equipment backup for those with life-support devices) and transportation must be established.

2. **Ventilator Dependent Recipients.**

(i) *Ventilator dependent recipients* may qualify for private duty nursing services if any one of the primary requisites are present and at least one qualified caregiver has been identified.

(ii) *Primary Requisites* – include, but may not be limited to, the following as qualifying criteria for nursing recipients:

(I) Mechanical ventilator support is necessary for at least six hours per day and appropriate weaning steps are in progress on a continuing basis.

(II) Frequent ventilator checks are necessary. Frequent ventilator checks are defined as daytime versus nighttime setting changes, weaning in progress, or

parameter checks a minimum of every eight hours with subsequent ventilator setting changes.

(III) Oxygen supplementation for ventilator dependent recipients is at or below an inspired fraction of 40 percent ($FiO_2$of 0.40).

(iii) *Qualified Caregiver*.

(I) The family must have at least one member capable of and willing to be trained to assist in the provision of care for the recipient in the home.

(II) The family must provide evidence of parental or family involvement and an appropriate home situation (for example, a physical environment and geographic location for the recipient's medical safety).

(III) Reasonable plans for emergencies (such as power and equipment backup for those with life-support devices) and transportation must be established.

Note: Any private duty nursing hours approved will be reduced by the number of hours of care which are provided or are available from other resources. In the event a child eligible for Medicaid is already attending or plans to attend public school, the case manager should contact the Special Education Coordinator within the appropriate school district to request that the child's Individual Education Program (IEP) committee meet to determine the student's need for related services. The names and contact information for the coordinators are on the education website at www.alsde.edu. The Individuals with Disabilities Education Act (IDEA) guarantees every child the right to a free, appropriate public education and related services in the least restrictive environment. The case manager may be asked to be part of the client's IEP team to facilitate the coordination of necessary related services. Related services needed in the school that are the same as services provided in the home should be closely coordinated. For example, a child needing nursing services should be evaluated and recommended for the appropriate level of care to ensure no break in services if services previously provided by Medicaid are subsequently provided by the school district. For children attending public school, the number of approved hours may be modified during the summer months and school breaks.

3. **Limitations**:

(i) Nursing services must be prescribed as medically necessary by a licensed physician as a result of an EPSDT screening referral, based on the expectation that the recipient's medical needs are adequately and safely met in the home.

(ii) All private duty nursing services require prior authorization. Additionally, the recipient must be under 21 years of age to qualify and must be Medicaid eligible. The recipient must require skilled nursing care which exceeds the caregiver's ability to care for the recipient without the assistance of at least four consecutive hours of skilled nursing care.

(iii) Major commitment on the part of the recipient's family is mandatory to meet the recipient's needs. The primary caregiver must sign the Private Duty Nursing Agreement for Care form agreeing to participate in and complete training. Additional caregivers identified for training must be indicated on the Private Duty Nursing Agreement for Care form. In the event that multiple caregivers exist, an adjustment in the hours approved for PDN will occur.

(iv) Medicaid does not provide private duty nursing services under the following circumstances:

(I) Observational care for behavioral or eating disorders, or for medical conditions that do not require medically necessary intervention by skilled nursing personnel;

(II) Services not prescribed to treat or improve a condition identified as a result of an EPSDT screening;

(III) Custodial, sitter, and unskilled respite services;

(IV) Services after the recipient is admitted to a hospital or a nursing facility; or

(V) Services after the recipient is no longer eligible for Medicaid.

(v) Medicaid allows hours for the continuation of private duty nursing services under the following circumstances:

(I) Temporary Illness: Private duty nursing hours may be provided for a period up to 90 days if the primary caregiver is incapacitated due to personal illness or illness of another family member who is dependent upon the caregiver and there is no other trained

caregiver available in the home. Temporary illness includes a required surgical procedure due to illness/disease, an illness which would be a danger to the child because of contagion, or an illness which is debilitating for a limited period. Medical documentation from the caregiver's attending physician is required. The number of hours approved is dependent upon the specific circumstances.

(II) Patient at Risk: Private duty nursing hours may be approved if the patient appears to be at risk of abuse, neglect, or exploitation in the domestic setting and a referral for investigation has been made to the appropriate state agency. The number of hours approved is dependent upon the specific circumstances.

(III) Sleep: Private duty nursing hours may be provided up to eight hours depending on the situation of the primary caregiver. For example, a single parent with no other family support may be granted a full eight hours while two parents serving as primary caregivers may require fewer hours or only hours on an occasional basis.

(IV) Work: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is at work plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. A Private Duty Nursing Verification of Employment/School Attendance Form must be completed providing documentation of work hours.

(V) School: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is attending class plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. A current course selection guide published by the school, validated class schedule from school, curriculum guide and transcripts of previous courses taken must be provided. The coursework must be consistent with the requirement for obtaining a GED, college degree, or some other type of certification for employment. Courses selected must follow a logical approach with class hours being taken one after the other unless the course has been indicated by school officials as "closed".

4. A care plan must be developed and submitted with each request for service documenting the extent of nursing needs. Careful review of the patient's status and needs should be made by each professional participating in the patient's care. Each discipline should formulate goals and objectives for the patient and develop daily program components to meet these goals in the home. This plan must include the following:

(i) designation of a home care service coordinator;

(ii) involvement of a primary care physician with specific physician orders for medications, treatments, medical follow-up, and medical tests as appropriate;

(iii) family access to a telephone;

(iv) a plan for monitoring and adjusting the home care plan;

(v) a defined backup system for medical emergencies;

(vi) a plan to meet the educational needs of the patient;

(vii) a clearly shown planned reduction of private duty hours; and

(viii) criteria and procedures for transition from private duty nursing care, when appropriate.

5. At each certification, the care plan will be denied, approved, or additional information will be requested. The patient should be transitioned to the most appropriate care when the patient no longer meets the private duty nursing criteria. The most appropriate care may be home care services, nursing home placement, or the Home and Community Based Waiver Program.

6. Cost Effectiveness: The cost of private duty nursing services, when combined with the total daily cost of all Medicaid reimbursable services, should not exceed the cost of available hospital care for which the recipient would qualify if private duty nursing services were not provided.

7. Private duty nursing providers are required to indicate the date and time of all services provided on a signature log maintained in the patient's record with a copy retained by the patient/parent or guardian. The nurse providing services and the caregiver must sign each entry.

8. Private duty nursing providers are required to submit to Medicaid a copy of the Home Health Certification and Plan of Care form (HCFA-485), the Medical Update and Patient Information form (HCFA-486), the Private Duty Nursing Agreement for Care Form (Form 166), and the EPSDT Referral for Services form (Form 167) for Medicaid to consider authorization for services.

9. Private duty nursing providers are required to submit the Home Health

Certification and Plan of Care form (HCFA-485) and the Medical Update and Patient Information form (HCFA-486) to Medicaid for continued services at least fourteen (14) days prior to the recertification due date. Recertification not received timely will be approved when criteria are met based on the date of receipt.

10. Failure by the provider to comply with agency rules and program policies contained in the applicable Private Duty Nursing Services Program Manual may result in recoupments and termination of the provider contract.

(i) Air Ambulance - Refer to Rule 560-X-18-. 15.

(j) Environmental Lead Investigators - a qualified investigator must have graduated from a four-year college or university with a minimum of 30 semester hours or 45 quarter hours of combined course work in biology, chemistry, environmental science, mathematics, physical science, or a minimum of, or evidence of, five years or more of permanent employment in an environmental health field. Any person employed must have successfully completed the training program for environmentalist conducted by the Alabama Department of Public Health before being certified by the Alabama Department of Public Health.

1. Environmental Lead Investigations are billable as a unit of service. A unit of service is the investigation of the home or primary residence of an EPSDT eligible child who has an elevated blood lead level. Testing of substances which must be sent off-site for analysis, or any non-medical activities such as removal or abatement of lead sources, or relocation efforts are not billable as part of an Environmental Lead Investigation.

Author: Kaye Melnick, EPSDT Program Manager, Medical Support Programs
Statutory Authority: State Plan, Attachment 3.1-A; 42 CFR Section 440.110, Section 441.56(2)(c); Omnibus Budget Reconciliation Act of 1989.
History: Rule effective October 1, 1982, September 11, 1992, January 11, 1994, September 13, 1994, September 12, 1995, August 14, 1996, November 14, 1996, and May 10, 1999. **Amended:** Filed October 19, 2001; effective January 16, 2002. **Amended:** Filed February 18, 2005; effective May 26, 2005. **Amended:** Filed July 20, 2006; effective October 17, 2006. **Amended:** Filed April 20, 2009; effective July 16, 2009.

Chapter 12. Home Health

Rule No. 560-X-12-.01. Home Health Care – General.

(1) Alabama Medicaid Home Health Care services are available for all Medicaid eligible persons of any age who meet the admission criteria on the basis of a reasonable expectation that a patient's medical, nursing, and social needs can adequately be met in the patient's place of residence.

(2) Anyone may refer a person who is in need of home health care, under the care of a physician, and in need of part-time nursing, to a participating agency.

Author: Georgette Harvest, Associate Director, Project Development/Policy Unit, Long Term Care Division.
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 440.70; and State Plan.
History: Rule effective October 1, 1982. Amended: Filed December 18, 2000; effective March 12, 2001.

Rule No. 560-X-12-.02. Admission Criteria.

(1) To be eligible for home health care, a recipient must meet all of the following criteria
(a) The recipient's illness, injury, or disability prevents the recipient from going to a physician's office, clinic or other outpatient setting for required treatment; as a result, he or she would, in all probability, have to be admitted to a hospital or nursing home because of complications arising from lack of treatment,
(b) The recipient is unable to leave home under normal circumstances. Leaving home requires a considerable taxing effort by the recipient, and absences from the home are infrequent, of relatively short duration, and for medical reasons, and
(c) The recipient is unable to function without the aid of supportive devices, such as crutches, a cane, wheelchair or walker and requires the use of special transportation or the assistance of another person.

Author: Georgette Harvest, Associate Director, Project Development/Policy Unit, Long Term Care Division.
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 440.70; and State Plan.
History: Rule effective October 1, 1982. Amended December 12, 1988. Amended: Filed December 18, 2000; effective March 12, 2001.

Rule No. 560-X-12-.03. Provider Requirements for Participation.

(1) Only in-state agencies are eligible for participation.

(2) A home health agency is a public agency, private non-profit organization or proprietary agency which is primarily engaged in providing part-time or intermittent skilled nursing services and home health aide services to patients in their homes.

(3) To become a Medicaid home health care provider, the home health agency must:
(a) Be certified to participate as a Medicare provider;
(b) Be certified by the Division of Health Care Facilities of the Alabama Department of Public Health as meeting specific statutory requirements and as meeting the Conditions of Participation;

(c) Request in writing to Alabama Medicaid Agency (Medicaid) to become a provider of Medicaid home health care, and enclose a copy of the agency's most recent cost study report showing discipline costs; and

(d) Agree to sign and to comply with the terms set forth in the agreement with Medicaid.

(4) Medicare cost reports must be available for review by the Alabama Medicaid Agency upon request.

(5) A copy of any Medicare audit adjustment or settlement must be submitted to Medicaid within thirty (30) days of receipt by the home health agency.

Author: Priscilla Miles, Associate Director, LTC Program Management Unit
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 440.70; and State Plan.
History: Rule effective October 1, 1982. Amended February 9, 1988 and September 9, 1988.
Amended: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-12-.04. Provider Termination and/or Change of Ownership.

(1) A participating agency has the right to withdraw from the Medicaid program after giving written notice to Medicaid of its intent at least thirty (30) days in advance.

(2) The State may terminate the home health agency's participation in the Medicaid program in cases involving fraud or willful or grossly negligent non-compliance.

(3) Medicaid must be notified in writing within thirty (30) days of the date of agency owner and/or name change. The existing contract will be terminated and a new contract must be signed if the agency desires to continue participation in the Medicaid program.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 434.6; and State Plan. Rule effective October 1, 1982.

Rule No. 560-X-12-.05. Covered Services.

(1) If ordered by the patient's physician, and authorized by Medicaid, a professional registered nurse employed by a certified home health agency can provide part-time or intermittent nursing services to a patient.

(a) The registered nurse is responsible for a nursing care plan, which is made in accordance with the physician's written plan of care.

(b) Restorative, preventive, maintenance, and supportive services are covered.

(2) Licensed Practical Nurse Services

(a) If ordered by a patient's physician, a licensed practical nurse, supervised by a professional registered nurse, employed by a participating home health agency, can provide intermittent or part-time nursing services to the patient when assignment is made by the professional registered nurse.

(b) LPN services are assigned and provided in accordance with existing State Law.

(3) Home Health Aide/Orderly Services

(a) A home health aide/orderly can provide personal care and services as specified in the physician's plan of treatment.

(b) These services can be provided on a part-time basis only when they are supervised by the nurse who is responsible for the care of the patient and services are authorized by Medicaid.

(4) Supervisory visits by the registered nurse must be performed at least every 60 days when services are provided by the LPN, home health aide, or orderly.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 441.15; and State Plan.
History: Rule effective October 1, 1982. Effective date of amendment August 9, 1985. **Amended:** Filed September 20, 2006; effective December 13, 2006.

Rule No. 560-X-12-.06. Noncovered Services.

(1) There is no coverage under the Medicaid Home Health Care plan for visits by paramedical personnel, physical therapists, speech therapists, occupational therapists, and inhalation therapists.

(2) Sitter service, private duty nursing service, medical social workers, and dietitians are not covered by Medicaid.

(3) Supervisory visits made by a professional registered nurse to evaluate appropriateness of services being rendered to a patient by an LPN, home health aide, or orderly are considered as administrative costs to the agency and may not be billed as skilled nursing services.

(4) The registered nurse will provide and document in the case record on-site supervision of the LPN, home health aide, or orderly at least every 60 days. The registered nurse will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the worker.

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 441.15; and State Plan.
History: Rule effective October 1, 1982. **Amended:** Filed September 20, 2006; effective December 13, 2006.

Rule No. 560-X-12-.07. Supplies, Appliances, and Equipment.

(1) Such items as are specified by Medicaid are available for use in the home.

(2) See the chapter covering supplies, appliances, and durable medical equipment for further information.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 440.70; and State Plan. Rule effective October 1, 1982.

Rule No. 560-X-12-.08. Physician Certification and Recertification.

(1) An eligible Medicaid recipient may be considered for home health care upon the recommendation of a medical doctor licensed in the State of Alabama.

(2) The patient's attending physician must certify the need for home health services and provide written documentation to the home health provider regarding the recipient’s condition which justify that the patient meets home health criteria. The attending physician must be an active Medicaid provider licensed in the State of Alabama.

(3) The physician must recertify care every sixty (60) days if home services continue to be necessary.

Author: Georgette Harvest, Associate Director, Project Development/Policy Unit, Long Term Care Division.
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 440.70; and State Plan.
History: Rule effective October 1, 1982. Amended: Filed December 18, 2000; effective March 12, 2001.

Rule No. 560-X-12-.09. Visits.

(1) A visit is a personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of a certified Medicaid home health agency.

(a) Home health care visits to Medicaid recipients must be medically necessary and in accordance with a Medicaid Home Health Certification form established by a licensed physician. Home Health records are subject to on-site audits and desk reviews by the professional staff of the Alabama Medicaid Agency.

(b) Home health care visits are limited to one hundred four (104) per calendar year.

(2) If a Medicaid recipient receiving home health visits is institutionalized and is referred to home health upon discharge from the institution, a new Medicaid Home Health Certification form must be completed and retained by the home health agency.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 441.15; and State Plan. Rule effective October 1, 1982. Amended July 8, 1983; January 8, 1986 and January 13, 1988. Effective date of this amendment February 9, 1989.

Rule No. 560-X-12-.10. Medicare/Medicaid Eligible Recipients.

Persons eligible for Medicare and Medicaid are entitled to all services available under both programs, but a claim must be filed with Medicare if the services are covered by Medicare. A patient may not receive home visits under both programs simultaneously. If Medicare terminates coverage, Medicaid may provide visits.

Medicare deductibles and co-insurance amounts for eligible Medicare/Medicaid recipients are not applicable for Home Health services. (Section 930 - PL 96-499)

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 431.625; and State Plan. Rule effective October 1, 1982.

Rule No. 560-X-12-.11. Billing of Medicaid Recipients by Providers.

(1) The Home Health Agency agrees to accept as payment in full the amount paid for covered home health services, and cannot make any additional charges to the recipient, sponsor, or family of the recipient.

(2) Medicaid recipients may be billed by providers for noncovered services. See Rule No. 560-X-12-.06 for a listing of noncovered services.

(3) Medicaid recipients may be billed for home health services provided by agencies which do not have a contract with the Alabama Medicaid Program.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 447.15; and State Plan. Rule effective July 9, 1984.

Chapter 13. Supplies, Appliances, and Durable Equipment

Rule No. 560-X-13-.01. Supplies, Appliances, and Durable Medical Equipment - General.

(1) Effective July 1, 1978, supplies, appliances, and durable medical equipment are available as Medicaid program benefits to Medicaid eligibles of any age living at home.

(2) The covered medical supplies, appliances, and durable medical equipment are for medical therapeutic purposes, must be ordered by the attending physician in connection with his plan of treatment, and the items will minimize the necessity for hospitalization, nursing home, or other institutional care.

(3) A recipient does not have to be a Home Health Care patient in order to avail herself/himself of this program.

(4) The provider is responsible for educating the recipient in the use of the equipment. The provider is also responsible for delivery and set up of the equipment.

(5) Standard supplies, appliances, and durable medical equipment covered by Medicaid are listed in Chapter 14, of The Alabama Medicaid Provider Manual. Medical equipment, supplies, and appliances not listed as covered services in Chapter 14 of the Alabama Medicaid Provider Manual may be requested for coverage by submitting the request to the Long Term Care Division for review and consideration. It will be the provider's responsibility to supply Medicaid with the necessary medical documentation which justifies the need of the requested items.

(6) Requests for items that are covered by Medicaid which are outside the normal benefit limits, due to damage beyond repair or other extenuating circumstances must be submitted to the Long Term Care Division for review and consideration. It will be the provider's responsibility to supply Medicaid with the necessary documentation which justifies the need for the requested items.

Author: Patricia Harris, Administrator, LTC Program Management Unit
Statutory Authority: State Plan; 42 CFR Section 440.70; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended November 11, 1985, March 10, 1997, and July 9, 1997. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.02. Participating Agencies and Suppliers.

(1) Participating agencies are those Home Health Agencies contracted with Alabama Medicaid Agency for this program.

(2) Participating suppliers are those pharmacies and medical equipment suppliers contracted with Alabama Medicaid Agency for this program.

(3) The provider's business must be physically located within the state of Alabama or within a 30-mile radius of the state of Alabama. Suppliers located more than 30- miles from the border of Alabama may be enrolled only as follows:

(a) For specialty equipment and supplies such as augmentative communication devices and vest airway clearance systems which are not readily available in state;

(b) For supplies and equipment needed as the result of a transplant or unique treatment approved out of state as the result of an EPSDT referral. Suppliers will be enrolled by the Medicaid fiscal agent on a temporary basis for these situations.

(4) There must be at least one person present to conduct business at the physical location. Answering machines and/or answering services are not acceptable as personal coverage during normal business hours (8:00 a.m. – 5:00 p.m.).

(5) Satellite businesses affiliated with a provider are not covered under the provider contract; therefore, no reimbursement will be made to a provider doing business at a satellite location. However, the satellite could enroll with a separate national provider number.

(6) The provider shall have no felony convictions and no record of noncompliance with Medicaid or Medicare regulations.

(7) The provider must submit a copy of a current business license to the Medicaid fiscal agent.

(a) Medicaid's fiscal agent enrolls supply, appliance, and durable medical equipment providers and issues provider contracts to applicants who meet the licensure or certification requirements of the State of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

(b) A copy of the approved Medicare enrollment application is required.

(8) Providers must notify Medicaid's fiscal agent in writing of any changes to the information contained in its application at least 30 business days prior to making such changes. These changes may include, but are not limited to, changes in ownership or control, federal tax identification number, or business address changes.

(9) All Alabama Medicaid DME and medical supply providers must submit copies of their Medicare Accreditation and their Medicare Surety Bonds to the Alabama Medicaid Agency's, Long Term Care (LTC) Policy Advisory Unit.

(a) The Alabama Medicaid DME and medical supply providers are required to have a $50,000 Surety Bond for each NPI by October 1, 2010.

(b) DME providers requesting to enroll as an Alabama Medicaid provider will be required to have a $50,000 Surety Bond for three years before qualifying for the $100,000 two-year volume exemption as referenced in rule (12)(f) below.

(10) Failure of Medicaid DME and medical supply providers to comply with these requirements will result in their termination from the Alabama Medicaid Program.

(11) Alabama Medicaid DME and medical supply providers must renew their required surety bonds annually, before the day and month that the first bond was effective to avoid a lapse in coverage, a denial of Medicaid reimbursements and termination as a provider of Medicaid DME and medical supply services.

(a) Proof of the renewal must be submitted to the Alabama Medicaid Agency at least 30 days prior to the individual bond's termination date. The assigned Medicaid DME provider location number and current physical location address must be included on the surety bond renewal document for the individual DME and medical supply business location being bonded.

(b) If there is a lapse in surety bond coverage dates, the provider will be denied payment for services that may have been otherwise covered by Medicaid, and the individual DME location without a current surety bond on file will be terminated as a provider of Medicaid DME and medical supply services.

(12) A DME and medical supply business is exempt from surety bond requirements if the DME and medical supply business:

(a) Is a DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety, and whose refund requests have been repaid as requested; or

(b) Is a government-operated Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); or

(c) Is a state-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics; or

(d) Are physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act; or

(e) Are physical and occupational therapists in private practice~~;~~ or

(f) Are providers who received $100,000 or less Medicaid payment in the past two calendar years; or

(g) Are pharmacy providers; or

(h) Are phototherapy providers who only provide phototherapy services for infants; or

(i) Are Federally Qualified Health Centers.

(13) DME suppliers who have been a Medicaid provider for five years or longer who are initially exempted from the Medicaid Surety Bond requirement as referenced in Rule (12)(a) of this section, will be subject to the Surety Bond requirement if the Medicaid Agency identifies a consistent problem with improper billing or fraudulent activity.

Author: Hattie N. Acheampong, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 434.6; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended: Filed December 17, 2001; effective March 15, 2002. **Amended:** Filed November 19, 2002. Effective February 14, 2003. **Amended:** Filed September 20, 2006; effective December 13, 2006. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed October 20, 2008; effective January 16, 2009. **Amended:** Filed October 20, 2009; effective January 15, 2010. **Amended:** Filed April 20, 2010; effective July 16, 2010.

Rule No. 560-X-13-.03. Supplies and Appliances.

(1) A written order or a signed prescription by the attending physician to a participating supplier determines medical necessity for needed covered items of supplies and appliances.

(2) A prescription is considered to be outdated by Medicaid when it is presented to the DME Provider/Medicaid's fiscal agent past ninety days from the date it was written.

(3) Medicaid considers a prescription to be valid for the dispensing of supplies for a period of twelve months. After the twelve month period of time, the recipient must be reevaluated by the physician to determine medical necessity for continued dispensing of medical supplies.

(4) Certain supplies and appliances require prior authorization by Alabama Medicaid Agency.

(5) Procedures for requesting and dispensing medical supplies and appliances for Medicaid recipients living at home are as follows:

(a) It is the responsibility of the recipient or authorized representative to obtain the prescription from the attending physician and take to a participating supplier.

(b) Upon receipt of the prescription, the supplier will:

1. verify Medicaid eligibility by checking the recipient's Medicaid number and verifying that number using AVRS or the Provider Assistance Center at Medicaid's fiscal agent. Recipient's eligibility must be verified on a monthly basis. Alabama Medicaid will not reimburse providers for items supplied to recipients in months where recipients have no eligibility;
2. obtain necessary managed care referrals and prior authorizations;
3. furnish the covered item(s) as prescribed;
4. collect the appropriate co-payment amount;
5. retain the prescription on file; and
6. submit the proper claim form to Medicaid's fiscal agent.

(6) Prescriptions are retained in patient's record or record file.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 440.70; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended November 11, 1985. Effective date of this amendment January 13, 1993. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No. 560-X-13-.04. Durable Medical Equipment.

(1) Prior authorization by Alabama Medicaid Agency is required for certain items of covered durable medical equipment.

(2) Medicaid covers the purchase of new durable medical equipment items for long term use. Long term use is defined as the use of durable medical equipment which exceeds six months. Medicaid covers the rental of new durable medical equipment items for the entire Medicaid population for six month or less. Selected medical equipment, which is prescribed as medically necessary, will be rented on a short-term basis for Medicaid eligible adults over age 21.

(3) Equipment may be purchased or rented for any Medicaid recipient meeting the established criteria.

(4) Durable Medical Equipment (DME) is equipment which:
- (a) can stand repeated use;
- (b) is used to serve a purpose for medical reasons; and
- (c) is appropriate and suitable for use in the home.

(5) Durable Medical Equipment is necessary when it is expected to make a significant contribution to the treatment of the patient's injury or illness or to the improvement of his physical condition.

(6) The cost of the item must not be disproportional to the therapeutic benefits or more costly than a reasonable alternative. The item would not serve the same purpose as equipment already available to the recipient.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 440.70; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended November 11, 1985; March 10, 1997; and July 9, 1997. Amended: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004. **Amended:** Filed February 20, 2008; effective May 16, 2008. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No. 560-X-13-.05. Method of Requesting Durable Medical Equipment.

(1) A Medicaid recipient's attending physician is responsible for prescribing any covered durable medical equipment that is medically necessary for use in the patient's home.

(2) The physician must complete a written order or prescription and give to the recipient or sponsor to take to the DME provider of their choice. The physician may also fax the prescription to the provider of the recipient's choice. The provider must submit the appropriate Alabama Prior Review and Authorization Request Form, Form 342 and any other pertinent medical information to the Medicaid Fiscal Agent. The information may be transmitted electronically or by mail. The Fiscal Agent will assign a prior authorization tracking number and transmit the request to the Medicaid Agency or its designee for review and approval.

(3) The Medicaid Agency or its designee will review the request and assign a status of approved, denied, or pending.

(a) If the request is approved, the provider and recipient will receive an approval letter with a ten-digit PA number. This information should be referenced on the claim for billing.

(b) If the request is denied, written notice will be sent to the provider and the recipient indicating the reason for denial. Information giving them their right to appeal is also included in this notice.

(4) All prior authorization requests for the purchase of durable medical equipment must be received by the Medicaid Fiscal Agent within 30 calendar days after equipment is dispensed.

(5) All prior authorization requests for certification of rental services received beyond the 30 calendar days of beginning services will be authorized for reimbursement effective the date of receipt at the Medicaid Fiscal Agent.

(6) All prior authorization requests for recertification of DME rental services must be submitted to the Medicaid Fiscal Agent within 30 calendar days of recertification date. Completed recertifications received beyond the established time limit will be authorized for reimbursement effective the date of receipt at the Medicaid Fiscal Agent.

(7) All prior authorization requests returned to the DME provider by Medicaid, if resubmitted, must contain the following:

(a) The appropriate Alabama Prior Review and Authorization Request Form,

(b) The EPSDT Referral/PMP (Primary Managed Care Provider) Form, if applicable,

(c) All necessary documentation to justify medical necessity,

(d) Current prescription.

(8) Prior authorization requests that are lacking necessary information (EPSDT screening, referrals, required attachment) are placed in pending status. Prior authorization requests that are pended based on the need for additional information will be denied if

information necessary to process the request is not received by the Medicaid Agency or its designee within 21 calendar days of the request.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 3.1-A; 42 CFR, Section 440.70; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended August 9, 1984; and March 10, 1997; and July 9, 1997. Amended: File August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No. 560-X-13-.06. Participating Supplier.

(1) The supplier furnishes only the approved item(s) indicated on the approval letter from the Alabama Medicaid Prior Approval Unit. This letter is generated and mailed by the Alabama Medicaid Fiscal Agent.

(2) The supplier is also responsible for verifying recipient's eligibility monthly.

(3) Upon furnishing durable medical equipment/supplies, the supplier must obtain a signature on any form he/she desires indicating that the equipment/supplies have been received by the recipient. If the recipient is unable to sign for the equipment/supply items, the supplier should verify the identity of the person signing for the items, e.g., relative, home health worker, neighbor.

(4) All forms and documentation must be retained in the patient record file by the supplier.

Author: Patricia Harris, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; 42 CFR Section 440.70; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended November 11, 1985; October 12, 1988; November 15, 1989; January 13, 1993; and March 10, 1997. Amended: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.07. Noncovered Items and Services.

(1) Items of a deluxe nature.

(2) Replacement of usable equipment.

(3) Items for use in hospitals, nursing homes, or other institutions.

(a) DME items may be provided in nursing homes or other institutions for children through the EPSDT Program.

(4) Items for patient/caring person's comfort and convenience.

Author: Hattie Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 441.15; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Effective date of this amendment March 10, 1997.
Amended: Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-13-.08. Medicare-Medicaid Eligibles and/or Qualified Medicare Beneficiaries.

(1) Refer to Rule No. 560-X-1-.14.

Authority: 42 CFR Section 431.625; State Plan, Attachment 3.2-A; and Title XIX, Social Security Act. Rule effective October 1, 1982. Amended January 8, 1985, and October 13, 1987. Emergency rule effective February 1, 1989. Effective date of this amendment May 12, 1989.

Rule No. 560-X-13-.09. Patient Identification.

(1) Refer to Rules 560-X-1-.09. and 560-X-1-.11.

Authority: State Plan; 42 C.F.R. Section 435.10; and Title XIX, Social Security Act. Rule effective October 1, 1982. Effective date of this amendment September 9, 1988.

Rule No. 560-X-13-.10. Reimbursement.

(1) Medicaid will reimburse for only those DME items indicated on the approval letter from the Alabama Medicaid Agency or its designee.

(2) Reimbursement will be made for item(s) covered by the Alabama Medicaid Agency for purchase or rentals as indicated on the DME Fee Schedule, using limits as established by Medicaid.

(3) Request for reimbursement must be submitted on the appropriate claim form.

(4) The contract supplier agrees to accept as payment in full the amount paid by Medicaid for covered items.

(a) The provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted and the patient will be responsible for the bill.

(b) The fact that Medicaid payment will not be accepted must be recorded in the patient's record. Refer to Rule No. 560-X-1-.07.

(5) Medicaid recipients may be billed for noncovered items.

(6) Medicaid recipients may be billed for items provided by noncontract suppliers.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan, Attachment 4.19-B, page 5; 42 C.F.R., Section 447.50; Section 447.252; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended July 9, 1984 and June 8, 1985. Amended: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No. 560-X-13-.11. Non-reimbursement.

(1) DME item(s) furnished by a supplier without receipt of an authorization to purchase by the Alabama Medicaid Agency will not be approved for reimbursement.

(2) Item(s) supplied to an individual who is not eligible during the month in which the item(s) are furnished, are not reimbursable.

(3) Medicaid recipients cannot be reimbursed directly by the Alabama Medicaid Agency.

Author: Patricia Harris, Administrator, LTC Program Management Unit.
Statutory Authority: 42 C.F.R., Section 447.252; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended January 8, 1985 and March 10, 1997.
Amended: Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.12. Cost-Sharing.

(1) Medicaid recipients are required to pay and suppliers are required to collect the designated co-pay amount for the rental/purchase of services, supplies, appliances and equipment, including crossover claims.

(2) The co-payment fee does not apply to services provided for pregnant women, recipients less than 18 years of age, emergencies, surgical fees, and family planning.

(3) A provider may not deny services to any eligible recipient due to the recipient's inability to pay the cost-sharing amount imposed.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 4.19-B, page 5; 42 CFR Section 447.50; and Title XIX, Social Security Act.
History: Rule effective June 8, 1985. Amended: Filed March 20, 2001; effective June 15, 2001. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No: 560-X-13-.13. Reimbursement for EPSDT-referred Wheelchair Systems.

(1) If no Medicare price is available for EPSDT-referred wheelchair systems, the reimbursement rate is established based on a discount from Manufacturers Suggested Retail Price (MSRP) instead of a "cost-plus" basis.

(2) Providers are required to submit MSRPs from three manufacturers for wheelchair systems (excluding seating system and add-on products) appropriate for the individual's medical needs.

(3) Requests submitted with less than three prices from different manufacturers must contain documentation supporting the appropriateness and reasonableness of equipment requested for a follow-up review by Medicaid professional staff. Provider must document nonavailability of required MSRPs to justify not sending in three prices.

(4) The established rate will be based on the MSRP minus the following discounts:

1. Manual Wheelchair Systems - 20% discount from MSRP.
2. Power Wheelchair Systems - 15% discount from MSRP.
3. Ancillary (add-on) products - 20% discount from MSRP.

(5) Suppliers requesting approvals for medical items must provide Medicaid with an expected date of delivery.

(6) For medical items approved based on medical necessity, Medicaid will indicate the time frame allowed for providers to dispense equipment on the approval letter.

(7) When a provider is unable to dispense equipment within the time frame specified on the approval letter, an extension may be requested with written justification as to the specific reason(s) why the equipment cannot be supplied timely. All requests for extensions must be submitted to Medicaid prior to the expiration date indicated on the approval letter.

(8) Medicaid will cancel approvals for medical items that are not dispensed timely when there is no justifiable reason for delay.

(9) The Medicaid screening provider and recipient will be notified when an approved request for equipment is cancelled due to provider noncompliance and the recipient will be referred to other Medicaid providers to obtain medical items.

Author: Patricia Harris, Administrator, LTC Program Management Unit
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 440.70; State Plan, Attachment 4.19-B; and OBRA '89.
History: Emergency rule effective September 1, 1993. Amended December 14, 1993. Emergency rule effective July 5, 1994. Effective date of this amendment August 12, 1994.
Amended: Filed June 21, 2004; effective September 15, 2004.

Rule No: 560-X-13-.14 Augmentative Communication Devices

(1) Effective July 1, 1998 coverage is provided for Augmentative Communication Devices (ACD) for eligible individuals who meet criteria set out herein. Prior authorization for the ACD service is required. Requests for prior authorization must be made on the appropriate Alabama Prior Review and Authorization Request Form. The request must include documentation regarding the medical evaluation by the physician and speech language pathologist and recipient information.

(2) ACDs are defined as portable electronic or non-electronic aids, devices, or systems determined to be necessary to assist a Medicaid-eligible recipient to overcome or improve severe expressive speech-language impairments/limitations due to medical conditions in which speech is not expected to be restored, and which enable the recipient to communicate effectively. These impairments include but are not limited to: apraxia of speech, dysarthria, and cognitive communication disabilities. These devices are reusable equipment items which must be a necessary part of the treatment plan consistent with the diagnosis, condition or injury, and not furnished for the convenience of the recipient or his family. ACD components and/or accessories prescribed or intended primarily for vocational, social, or academic development/enhancement and which are not necessary as described above will not be covered.

(3) The scope of services includes the following elements:
(a) Screening and evaluation,
(b) ACD, subject to limitations, and
(c) Training on use of equipment.

(4) Candidates under the age of 21 must meet all of the following criteria:
(a) EPSDT referral by Medicaid-enrolled EPSDT provider. Referral must be within one year of application for ACD. The EPSDT provider must obtain a referral from the *Patient 1st* primary care provider where applicable;
(b) Medical condition which impairs ability to communicate;
(c) Evaluation by required qualified, experienced professionals; and
(d) Physician prescription to be obtained after the evaluation and based on documentation contained in the evaluation.

(5) Candidates over the age of 21 must meet all of the following criteria:
(a) Referral from a primary care physician (*Patient 1st* PCP/PMP where applicable). Referral must be within one year of application for ACD;
(b) Medical condition which impairs ability to communicate;
(c) Evaluation required by qualified experienced professionals; and
(d) Physician prescription to be obtained after the evaluation and based on documentation provided in the evaluation.

(6) The candidate must be evaluated by qualified interdisciplinary professionals. Interdisciplinary professionals ***must*** include all of the following:
(a) Speech/Language Pathologist: This professional must meet all of the following criteria:

1. Have a master's degree in speech/language pathology from an accredited institution;
2. Have a Certificate of Clinical Competence in Speech/Language Pathology from the American Speech, Language, Hearing Association;
3. Have an Alabama license in speech/language pathology;
4. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs; and
5. Have current continuing education.

(b) Physician: This professional must meet all of the following criteria:
1. Be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the doctor performs such functions; and
2. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

Interdisciplinary professionals ***should*** also include, but may not be limited to, the following:

(c) Physical Therapist: This professional must meet all of the following criteria:
1. Have a bachelor's degree in physical therapy from an accredited institution;
2. Have an Alabama license in physical therapy; and
3. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

(d) Social Worker: This professional must meet all of the following criteria:
1. Have a bachelor's degree in social work from an accredited institution;
2. Have an Alabama license in social work; and
3. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

(e) Occupational Therapist: This professional must meet all of the following criteria:
1. Have a bachelor's degree in occupational therapy from an accredited institution;
2. Have an Alabama license in occupational therapy; and
3. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

(7) ACDs and services are only available through the Alabama Medicaid Agency prior authorization process. Requests for authorization must be submitted to Medicaid for review. Documentation must support that the client is mentally, physically, and emotionally capable of operating/using an ACD. The request must include documentation regarding the medical evaluation by the physician and recipient information:

(a) Medical Evaluation by Interdisciplinary Professionals must meet all of the following criteria:
1. Medical examination by physician to assess the need for an ACD to replace or support the recipient's capacity to communicate;

2. Status of respiration, hearing, vision, head control, trunk stability, arm movement, ambulation, seating/positioning and/or ability to access the device; and
3. Must have been conducted within 90 days of request for ACD.

(b) Recipient Information must include all of the following:
1. Name;
2. Medicaid number;
3. Date(s) of assessment;
4. Medical diagnoses (primary, secondary, tertiary); and
5. Relevant medical history.

(c) Sensory Status (by physician) must include all of the following:
1. Vision status;
2. Hearing status; and
3. Description of how vision, hearing, tactile, and/or receptive communication impairments affect expressive communication (e.g., sensory integration, visual discrimination).

(d) Postural, Mobility, and Motor Status must include all of the following:
1. Motor status;
2. Optimal positioning;
3. Integration of mobility with ACD; and
4. Recipient's access methods (and options) for ACD.

(e) Developmental Status must include all of the following:
1. Information on the recipient's intellectual/cognitive/developmental status; and
2. Determination of learning style (e.g., behavior, activity level).

(f) Family/Caregiver and Community Support Systems must include all of the following:
1. A detailed description identifying caregivers and support;
2. The extent of their participation in assisting the recipient with use of the ACD; and
3. Their understanding of the use and their expectations of the ACD.

(g) Current Speech, Language, and Expressive Communication Status must include all of the following:
1. Identification and description of the recipient's expressive or receptive (language comprehension) communication impairment diagnosis;
2. Speech skills and prognosis;
3. Communication behaviors and interaction skills (i.e., styles and patterns);
4. Description of current communication strategies, including use of an ACD, if any; and
5. Previous treatment of communication problems.

(h) Communication Needs Inventory must include all of the following:
1. Description of recipient's current and projected (e.g., within five years) speech/language needs;
2. Communication partners and tasks, including partners' communication abilities and limitations, if any; and
3. Communication environments and constraints which affect ACD selection and/or features.

(i) Summary of Recipient Limitations which must contain a description of the communication limitations.

(j) ACD Assessment Components must contain a justification for and use to be made of each component and accessory requested.

(k) Identification of *at least* three ACDs considered for recipient to include all of the following:

1. Identification of the significant characteristics and features of the ACDs considered for the recipient;
2. Identification of the cost of the ACDs considered for the recipient (including all required components, accessories, peripherals, and supplies, as appropriate);
3. Identification of manufacturer;
4. Justification stating why a device is the least costly, equally effective alternative form of treatment for the recipient; and
5. Medical justification of device preference, if any.

(l) Treatment Plan and Follow-Up must include all of the following:

1. Description of short-term and long-term therapy goals;
2. Assessment criteria to measure the recipient's progress toward achieving short-term and long-term communication goals;
3. Expected outcomes and description of how device will contribute to these outcomes; and
4. Training plan to maximize use of ACD.

(m) Documentation of recipient's trial use of equipment must include all of the following:

1. Amount of time;
2. Location; and
3. Analysis of ability to use equipment.

(n) Documentation of qualifications of speech/language pathologists and other professionals submitting portions of the evaluation must be present. Physicians are exempt from this requirement.

(o) A signed statement by submitting professionals that they have no financial or other affiliation with manufacturer, vendor, or sales representative of ACDs must be present. One statement signed by all professionals will suffice.

(8) Medicaid reserves the right to request additional information and/or evaluations by appropriate professionals.

(9) ACDs are subject to the following limitations. ACDs, including components and accessories, will be modified or replaced only under the following circumstances:

(a) Medical Change: Upon the request of recipient if a significant medical change occurs in the recipient's condition which significantly alters the effectiveness of the device.

(b) Age of Equipment: ACDs outside the manufacturer's or other applicable warranty which do not operate to capacity will be repaired. At such time as repair is no longer cost-effective, upon request by the recipient, replacement of identical or comparable component or components will be made. Full documentation of the history of the service, maintenance, and repair of the device must accompany such requests.

(c) Technological Advances: No replacements or modifications will be approved based on technological advances unless the new technology would meet a significant medical need of the recipient which is currently unmet by the present device.

(10) All requests for replacement or modification as outlined in A-C above will require a new evaluation and complete documentation. If new equipment is approved, the old equipment must be turned in.

(11) Invoice: The manufacturer's invoice must be forwarded to the Medicaid Agency or its designee before the prior authorization is approved.

(12) Trial Period: No communication components will be approved unless the client has used the equipment and demonstrated an ability to use the equipment. Prior authorization for rental may be obtained for a trial period. This demonstrated ability can be documented through periodic use of sample/demonstration equipment. Adequate supporting documentation must accompany the request.

(13) Repair: Repairs are covered only to the extent not covered by the manufacturer's warranty. Repairs must be prior authorized. Battery replacement is not considered repair and does require prior authorization.

(14) Loss/Damage: Replacement of identical components due to loss or damage must be prior authorized. These requests will be considered only if the loss or damage is not the result of misuse, neglect, or malicious acts by the users.

(15) Component/Accessory Limits: Components or accessories which are not medically required will not be approved. Examples of non-covered items include, but are not limited to, printers, modems, service contracts, office/business software, software intended for academic purposes, workstations, or any accessory that is not medically required.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 4.19-A; 42 CFR, Section 440.70; Title XIX, Social Security Act.
History: April 26, 1999. Amended: Filed August 21, 2001; effective November 16, 2001.
Amended: Filed October 20, 2008; effective February 3, 2009.

Rule No: 560-X-13-.15 Oxygen Therapy Coverage

(1) Effective December 1, 2000, Oxygen Therapy is covered for the entire Medicaid population based on medical necessity and must be prior authorized by the Medicaid Agency. Requests for prior authorization must be made on the appropriate Alabama Prior Review and Authorization Request Form. The request must be accompanied by appropriate medical and other required documentation.

(2) The medical diagnosis must indicate a chronic debilitating medical condition, with evidence that other forms of treatment (such as medical and physical therapy directed at

secretions, bronchospasm and infection) were tried without success and that continuous oxygen therapy is required. Oxygen will not be approved for PRN use only.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 4.19-A; 42 CFR, Section 440.70; Title XIX, Social Security Act.
History: New Rule: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed October 20, 2008; effective January 16, 2009.

Rule No. 560-X-13-.16 External Breast Prostheses

(1) Effective June 1, 2001, external breast prostheses following mastectomy for breast cancer are covered for all Medicaid-eligible recipients meeting the criteria.

(2) Coverage is available for the external breast prostheses when all of the following criteria are met:

(a) Recipient must be eligible for Medicaid on the date of service for provision of prostheses;

(b) The date of the mastectomy and the ICD-9 diagnosis code for which was performed (174.0-174.9, 198.81, 233.0) is provided in the clinical statement section of the appropriate Alabama Prior Review and Authorization Request Form; and

(c) The appropriate procedure codes are billed as indicated below:

Procedure Code	Description	Limits
L8000	Breast prosthesis, mastectomy bra, maximum of 4 on initial request.	6/year
L8015	External breast prosthesis garment, with mastectomy form	2/year
L8020	Breast prosthesis, mastectomy form	**
L8030	Breast prosthesis, silicone or equal	**
*L8035	Custom breast prosthesis, post mastectomy, molded to patient model	
*L8039	Breast prosthesis, not otherwise classified evaluated on a case-by-case basis with submission of pricing information and medical documentation	

*These codes will be reviewed on a case-by-case basis. Additional documentation may be requested to determine medical necessity for coverage.

**Limited to two of L8020 per year or one L8020 and one L8030 per year or two of L8030 per year or one L8030 and one L8020 per year.

(2) Requests for prior authorization must be made on the appropriate Alabama Prior Review and Authorization Request Form and submitted to the EDS Prior Authorization Unit to obtain approval before providing the prosthetic devices.

(3) Maximum calendar year limits apply to each of the procedures as indicated above.

Author: Patricia Harris, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; 42 CFR, Section 440.70; Title XIX, Social Security Act.
History: New Rule: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.17 Motorized/Power Wheelchairs

(1) Motorized/power wheelchairs are a covered benefit for patients who meet full Medicaid eligibility criteria and medical necessity. The patient must meet criteria applicable to wheelchairs pursuant to this chapter and the Medicaid Provider Manual and the following additional criteria:

(a) Documentation that a manual wheelchair cannot meet medical needs; and
(b) Documentation of long term need for the chair (6 months or longer).

(2) Application process: All requests for motorized/power wheelchairs are subject to the Medicaid Prior Approval provisions and the following additional provisions:

(a) Medical documentation to support diagnosis from the patient's attending physician who has conducted a medical evaluation consisting of medical history, physical examination, assessment, and plan of care.

(b) An evaluation by a Physical Therapist or Occupational Therapist who meets credentialing requirements as provided in the Motorized/Power Wheelchair section of the Medicaid Provider Manual, conducted at sites specified therein and in accordance with, and the completion of, a form approved and provided by Medicaid.

(c) A supplier providing motorized/power wheelchairs to recipients must be registered as a Rehabilitation Technology Supplier (RTS) by the National Registry of Rehabilitation Technology Suppliers (NRRTS). As an alternative, a supplier shall be certified as a Certified Rehabilitation Technology Supplier (CRTS) or Assistive Technology Professional (ATP) from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). After October 1, 2004, only suppliers who are certified may participate.

(d) Itemized list of items with pricing.

(3) Reimbursement will be made pursuant to Rule 560-X-13-.10.

(4) Limitations and Exclusions

(a) Patients may be approved for one motorized/power wheelchair every five years based on medical necessity/criteria.

(b) Home/environmental and vehicle adaptations, equipment and modifications are not covered.

(c) Repairs and/or replacement of parts require Prior Authorization.

Author: Ida Gray, Administrator, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 4.19-A; 42 CFR, Section 440.70; Title XIX, Social Security Act.

History: New Rule: Emergency Rule filed and effective June 20, 2003. Amended: Filed July 21, 2003; effective October 24, 2003. Amended: Filed June 21, 2004; effective September 15, 2004. **Amended:** Filed July 20, 2005; effective October 14, 2005. **Amended:** Filed October 20, 2008; effective January 16, 2009. **Amended:** Filed January 21, 2009; effective April 17, 2009.

Rule No. 560-X-13-.18 Basic Level Prosthetics, Orthotics, and Pedorthics for Adults.

(1) Basic level prosthetics, orthotics and pedorthics are covered benefits to Medicaid eligibles between the ages of 21 and 65 in a noninstitutional setting. These covered benefits are provided only by prior authorization from the Alabama Medicaid Agency and based on medical necessity. The patient must meet established Medicaid criteria applicable to prosthetic, orthotic, and pedorthic devices pursuant to this chapter and the Medicaid Provider Manual.

(a) For items to be covered, recipients must meet eligibility requirements, the devices must be reasonable and necessary to improve the functioning of a malformed body member or replace an absent body member, and meet all other applicable Medicaid statutory and regulatory requirements.

(b) Durable Medical Equipment (DME) providers of prosthetic, orthotic, and pedorthic devices for adults must be enrolled as an Alabama Medicaid Agency (AMA) provider and licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics.

(c) The provider is required to submit a copy of their license with all prior authorization requests.

(d) The provider must be practicing as a prosthetic, orthotic, or pedorthic practitioner in the State of Alabama at an accredited facility.

(e) Providers must keep a copy of the written prescription from the primary physician for the prosthetic or orthotic device in the recipient's file.

(f) The provider must have documentation of the education follow ups provided to the recipient of the use of the prosthetic and orthotic device in the recipient's file.

(2) For Medicaid to approve lower limb prosthesis, medical documentation must be submitted substantiating that a prosthesis is essential in order for the recipient to ambulate and that the recipient is motivated to ambulate.

(3) For Medicaid to approve an orthotic device, medical documentation must be submitted to show that the device supports or aligns movable parts of the body, prevents or corrects deformities, or improves functioning.

(4) For Medicaid to approve therapeutic shoes for diabetes, medical documentation must be submitted showing that the recipient has diabetes mellitus and other medical conditions justifying the need. Refer to DME Fee Schedule on the Alabama Medicaid Web site for Prosthetic, Orthotics, and Pedorthic reimbursement rates and benefit limits.

Author: Hattie Nettles, Associate Director, LTC Policy Advisory Unit.

Statutory Authority: State Plan Attachments 3.1-A and 4.19-B; 42 CFR, Section 440.70; Title XIX, Social Security Act.
History: New Rule: Filed December 17, 2007; effective March 17, 2008. **Amended:** Filed October 20, 2008; effective February 3, 2009.

Chapter 14. Family Planning

Rule No. 560-X-14-.01. Family Planning - General.

(1) Family planning services are defined as the services provided to:
(a) Prevent or delay pregnancy.

(2) Family planning services are available through providers enrolled with the Alabama Medicaid Agency, including hospitals, primary care clinics, Rural Health Clinics, Federally Qualified Health Centers, Provider-based Rural Health Clinics, the Statewide Family Planning Project, Planned Parenthood of Alabama, Inc. and private physicians.

(3) Acceptance of any family planning information or service is strictly voluntary on the part of the recipient, and no form of duress or coercion should be applied to gain such acceptance. Individuals are required to give written consent prior to receiving family planning services.

Author: Leigh Ann Payne, Program Manager, Medical Services Division
Statutory Authority: State Plan; 42 C.F.R. Section 440.40(c); Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended October 9, 1984, December 10, 1987, August 12, 1992, September 11, 1993, and October 13, 1998. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-14-.02. Eligible Individuals.

(1) Eligible individuals are those females of childbearing age and males of any age, including minors who may be sexually active.

(2) In determining recipient eligibility for family planning services, childbearing age is considered to be between 10 and 55 years of age.

Authority: State Plan; 42 C.F.R., Section 441.20; Title XIX, Social Security Act. Rule effective October 1, 1982. Amended December 10, 1987. Effective date of this amendment August 12, 1992.

Rule No. 560-X-14-.03. Family Planning Services.

(1) The following services are covered services when provided by Family Planning providers. Details on criteria required for each type of service is listed in Appendix C of the Alabama Medicaid Provider Manual.

(a) Initial Visit - an in-depth evaluation of a new patient requiring the establishment of medical records, evaluation of the data obtained, comprehensive history, complete physical examination, appropriate diagnostic lab tests and/or procedures, contraceptive and sexually transmitted disease prevention counseling, and issuance of supplies or prescription as indicated. An initial visit is limited to one per provider per individual, per lifetime.

(b) Annual Visit - the re-evaluation of an established patient requiring an update to medical records, evaluation of the new data obtained interim history, complete physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling, and adjustment of contraceptive management as indicated. An annual visit is limited to one per calendar year.

(c) Periodic Revisit - a follow-up evaluation of a new or existing family planning condition. Services include a review with update of history, a review of the effectiveness of current contraceptive method with counseling regarding any existing problems and adjustment of contraceptive method to include issuance of supplies as indicated. This visit includes scheduled follow-up, as medically indicated, of chosen birth control method. Limited to no more than four (4) revisits per calendar year.

(d) Home Visit - a brief evaluation by a medical professional in the home of established patients. Services provided include an abbreviated history, weight and blood pressure, and contraceptive counseling with issuance of contraceptive supplies if indicated. A follow-up clinic appointment is scheduled if indicated. Limited to one visit during the 60-day post partum period.

(e) Extended Family Planning Counseling Visit - a separate and distinct counseling service provided at the time of the post partum visit requiring a minimum of 10 minutes of face-to-face contact. Limited to one service during the post partum examination. This service is not available to an individual that has undergone a sterilization procedure.

(f) Routine laboratory screening tests such as pregnancy testing, STD/HIV test, Pap smear, hemoglobin or hematocrit and urinalysis are covered when performed as a part of the initial/annual family planning service.

(2) The following procedures are covered under Family Planning if provided for contraceptive purposes:

(a) Insertion or removal of implantable contraceptive capsules when performed by or under the supervision of a physician.

(b) Insertion or removal of intrauterine devices when performed by or under the supervision of a physician.

(c) Fitting of a diaphragm when performed by or under the supervision of a physician.

(3) Medically approved pharmaceutical supplies and devices such as oral contraceptive pills, foams, jellies, creams, diaphragms, intrauterine devices, injections and implants are covered if provided for family planning purposes.

Author: Leigh Ann Payne, Program Manager, Medical Services Division
Statutory Authority: State Plan; 42 C.F.R. Section 441.20; Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended February 9, 1987, December 10, 1987, June 12, 1991, August 12, 1992, September 11, 1993, and August 12, 1995.. **Amended:** Filed February 18, 2003; effective May 16, 2003. **Amended :** Filed February 18, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-14-.04. Sterilizations.

Surgical procedures for male and female recipients as a method of birth control are covered services under the rules and regulations set forth below:

(1) Rules and Regulations Concerning Federal Financial Participation for Sterilization, effective February 6, 1979, apply in the following instances:

(a) The individual is at least twenty-one (21) years old at the time consent is obtained;

(b) The individual is not a mentally incompetent individual;

(c) The individual has voluntarily given informed consent in accordance with all requirements;

(d) At least 30 days, but not more than 180 days have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.

(e) An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent for the sterilization was given. In case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

(2) Mentally Incompetent or Institutionalized Individuals: Payment is not available for the sterilization of a mentally incompetent or institutionalized individual.

(3) Claims for Sterilization Procedure Performed on or after February 6, 1979:

Sterilization claims will be paid only when in conformity with the guidelines set forth in this regulation, and completion of consent forms, [three (3) copies of form 193]. See Chapter 28 of this Code for consent form sample. In the event that the recipient does not meet the above requirements and elects to have the sterilization, the provider may bill the recipient for the sterilization.

(4) Sterilization consent forms are to be completed as follows:

(a) The patient's birthdate will reflect the patient was at least 21 years of age when he/she signed and dated the consent form.

(b) The counselor's signature date, as well as the patient's signature date will reflect at least 30 days, but not more than 180 days have passed prior to the procedure being done.

(c) Due to the wording of the physician's statement, the physician signature and date can only be affixed after the procedure has been completed. The physician statement and signature must reflect at least 30 but not more than 180 days have passed since the patient signed.

(d) It is of vital importance that each copy of the consent form 193 be utilized in the correct manner. When these forms are fully completed:

Copy 1 - Patient - to be given to the patient.

Copy 2 - Payment Purpose - to be utilized for payment.

Copy 3 - Patient's Permanent Record - to be placed in the patient's permanent record with copies being made to accommodate both the facility and physician.

(5) Providers must submit a sterilization consent form with his claim or it will be returned. The provider must submit the claim within the time frame set forth by regulations in Chapter 1 of this Code, General.

(6) Sterilization reversals requested as a result of a previous voluntary surgical sterilization will not be covered.

Author: Leigh Ann Payne, Program Manager, Medical Services Division
Statutory Authority: State Plan; 42 C.F.R. Sections 441.250, 441.251, 441.252, 441.253, 441.257, 441.258, and Appendix to Subpart F; Title XIX, Social Security Act. **History:** Rule effective October 1, 1982. Amended July 9, 1984, October 11, 1986, December 10, 1987, August 12,1992, and September 11, 1993. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-14-.05. Non-family Planning Services.

(1) Medically necessary procedures for the treatment of illness or injury which would inevitably have a secondary effect of rendering an individual incapable of reproducing are not classified as family planning procedures. Claims for such procedures are payable based on determination of medical necessity under the same procedures used by the fiscal agent in claims processing.

(2) Sterilization by hysterectomy is not a family planning covered service.

(3) Abortions are not covered as a family planning service. Refer to Chapter 6 of this Code, Physician's Program.

(4) Hospital charges resulting from recipient deciding not to be sterilized after entering the hospital for sterilization purposes cannot be reimbursed as a family planning service.

(5) Removal of an IUD because the recipient has a uterine/pelvic infection is not considered a family planning service and is not reimbursable as such.

(6) Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions are not considered family planning services.

(7) Medical complications requiring treatment (i.e., perforated bowel) caused by or following a family planning procedure cannot be a covered family planning service.

(8) Any procedure/service provided to a woman who is known to be pregnant cannot be considered a family planning service.

(9) Removal of contraceptive implants due to medical complications are not family planning services; however, the removal may be covered as a medical service through the Physician's Program.

(10) Diagnostic or screening mammograms are not considered family planning services.

Author: Leigh Ann Payne, Program Manager, Medical Services Division
Statutory Authority: State Plan; 42 C.F.R., Sections 401 et seq.; 441.250, 441.251, 441.252, and 441.255; Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended July 9, 1984, March 12, 1987, December 10, 1987, August 12, 1992, and September 11, 1993. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-14-.06 - Family Planning Waiver.

(1) The Family Planning Waiver program operates under an approved Section 1115(a) Research and Demonstration Waiver, which extends Medicaid eligibility for family planning services to all women of childbearing age (19 through 55), (who do not have creditable health insurance coverage as defined by the Health Insurance Portability and Accountability Act (HIPAA) and have not had a sterilization procedure performed) with incomes at or below 133% of the federal poverty level who would not otherwise qualify for Medicaid. The waiver has been approved for three (3) years and may be renewed with CMS's approval.

(2) The program represents a collaborative effort between the Alabama Medicaid Agency and the Alabama Department of Public Health.

(3) The Family Planning Waiver Program is officially known as the "Plan First Program."

(4) Enrolled Medicaid providers are eligible to provide family planning services but must also enroll as a network provider by completing a Plan First agreement. Upon receipt of the signed agreement, Medicaid's fiscal agent will add the Plan First provider specialty code to the provider's existing record. Those providers that only do tubal ligations do not have to enroll as a Plan First provider nor do anesthesia providers for these procedures. There are no changes to current provider eligibility policies due to this waiver.

(5) The following are the eligible groups for the Family Planning Waiver:

(a) Women 19 through 55 years of age who have SOBRA-eligible children (poverty level), who become eligible for family planning without a separate eligibility determination. They must answer yes to the Plan First question on the application. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

(b) SOBRA poverty level pregnant women 19 through 55 years of age are automatically eligible for family planning services after 60 days postpartum without a separate eligibility determination if they meet all eligibility criteria. Income is verified at initial

application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

(c) Other women age 19 through 55 who are not pregnant, postpartum or who are not applying for a child must apply using a simplified shortened application. An eligibility determination will be completed using poverty level eligibility rules and standards. Client declaration of income will be accepted unless there is a discrepancy. The agency will process the information through data matches with state and federal agencies. If a discrepancy exists between the client's declaration and the income reported through data matches, the client will be required to provide documentation and resolve the discrepancy. Eligibility is redetermined every 12 months.

Newly awarded family planning recipients will receive a Medicaid plastic card based on the same criteria as other Medicaid recipients. Providers will be informed at the time of eligibility verification that services are limited to family planning only. If a recipient has received a plastic card in the recent past, another card will be sent only upon request.

(6) In order to be eligible for Family Planning Services a woman must:

(a) Furnish a Social Security number or proof they have applied for one

(b) Be a female resident of Alabama age 19 through 55

(c) Meet citizenship and alienage requirements

(d) Have family income at or below 133% of the federal poverty level

(e) Cooperate in establishing third party medical benefits, and apply for all benefits to which she may be entitled

(7) Once determined eligible, a woman will remain eligible for benefits until the termination of the waiver unless she disenrolls or is terminated from the waiver for one of the following reasons:

(a) The recipient's gross countable family income exceeds 133% of the federal poverty level

(b) The recipient does not reside in Alabama

(c) The recipient is deceased

(d) The recipient has received a sterilization procedure

(e) The recipient requests her family planning benefits be terminated

(f) The recipient is outside the family planning age limit of 19 through 55

(g) The recipient is eligible for Medicare benefits

(h) The recipient becomes eligible for another Medicaid program

(i) The recipient fails to cooperate with the Medicaid Agency in the eligibility process, receipt of services or Medicaid Quality Control Review

(j) The recipient is determined ineligible due to fraud, misrepresentation of facts, or incorrect information

(8) Medical services covered for the extended eligibles are limited to birth control services and supplies only. This includes:

(a) All currently covered family planning methods

(b) Outpatient tubal ligation
(c) Doctor/clinic visits (for family planning only)
(d) HIV pre and post test counseling visits

(9) Eligible participants have freedom of choice in the selection of an enrolled network provider.

(10) Under this waiver, Medicaid also reimburses for care coordination activities provided by licensed social workers or registered nurses associated with the Alabama Department of Public Health who have received training on the Family Planning Program. Services are available to all women, regardless of the care site. Care coordination will be reimbursed on a per hour basis in 5 minute increments. Enrolled providers must refer participants to the Health Department to initiate care coordination.

(11) Family Planning Care Coordination will only be available for women eligible through the Family Planning Waiver. Recipients eligible for other Medicaid eligibility programs will be eligible for the regular benefit packages established for those programs and will not be eligible for the enhanced family planning care coordination services.

(12) The Family Planning Waiver program operates under approved Terms and Conditions as specified in the waiver and the Operational Protocol Manual.

Author: Leigh Ann Hixon, Program Manager Medical Services Division.
Statutory Authority: Section 1115(a): Sections 1902(a) (10) (b), (e) (5) and (6) of the Social Security Act.
History: New Emergency Rule filed August 28, 2000; effective October 1, 2000. **Amended:** Filed September 21, 2000, effective December 11, 2000. **Amended:** Filed September 21, 2001, effective December 14, 2001. **Amended:** Filed October 20, 2009, effective January 15, 2010.

Rule No. 560-X-14-.07. Consent for Health Services for Certain Minors and Others.

(1) Chapter 1 of this Code, General, contains references to the Code of Alabama, 1975, regarding the rights of minors to consent to any legally authorized medical, dental, or other health services for himself or herself.

(2) Illiterate recipients may give consent for family planning services by making their mark (i.e., "X") on the appropriate line. This type of consent for services must be witnessed by an adult with his/her signature after the phrase "witnessed by."

Authority: Code of Alabama, 1975, Section 22-8-1, et seq.; 42 C.F.R., Sections 401 et seq., 441.20. Rule effective October 1, 1982. Amended December 10, 1987. This amendment effective August 12, 1992.

Rule No. 560-X-14-.08. Family Planning Drugs.

(1) The co-payment on prescription drugs, and any indicated refills for Medicaid recipients does not apply to drugs and supplies designated as family planning items.

(2) Medically approved pharmaceutical supplies and devices such as oral contraceptive pills, diaphragms, intrauterine devices, injections and implants are covered if provided for family planning purposes.

Author: Leigh Ann Payne, Program Manager, Family Planning
Statutory Authority: State Plan; 42 C.F.R. Section 401, et seq.; Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended August 12, 1992. **Amended:** Filed February 18, 2003; effective May 16, 2003.

Rule No. 560-X-14-.09. Billing of Medicaid Recipients by Providers.

(1) Refer to Chapter 1 of this Code for general information regarding providers billing Medicaid recipients.

(2) Medicaid recipients are exempt from co-payment requirements for family planning services.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.15. Rule effective August 12, 1992. Effective date of this amendment August 12, 1995.

Rule No. 560-X-14-.10. Reports.

(1) The Medicaid fiscal agent will provide a report on sterilization claims adjudicated to be used for reporting expenditures to Centers for Medicare and Medicaid Services.

(2) The fiscal agent shall generate a report of Family Planning expenditures to be used for reporting expenditures to the Centers for Medicare and Medicaid Services.

Author: Leigh Ann Payne, Program Manager, Medical Services Division
Statutory Authority: State Plan; 42 C.F.R., Section 401, et seq.; Title XIX, Social Security Act.
History: Rule effective October 1, 1982, and August 12, 1992. **Amended:** Filed March 20, 2003; effective June 16 2003.

Rule No. 560-X-14-.11. Alabama Medicaid Provider Manual.

(1) The Alabama Medicaid Provider Manual, including Appendix C, which details the elements of each family planning visit, instructions for completion of forms, and procedures to follow in the administration of the local program, is provided to each enrolled provider.

(2) Family planning providers will be required to follow procedures outlined in the manual. Failure to do so may result in the recoupment of claims paid to the provider.

Author: Leigh Ann Payne, Program Manager, Medical Services Division
Statutory Authority: State Plan; 42 C.F.R., Section 401, et seq.; Title XIX, Social Security Act.
History: Rule effective August 12, 1992. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Chapter 15 – Dental Program

Rule No. 560-X-15-.01. Dental Program - General.

(1) The availability of certain dental health care services for eligible children under age 21 is required through the Alabama Medicaid Program as part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

(2) Dental providers must be licensed to practice in the State in which the service is provided. Dentists are exempt from a contract requirement at the present time, but must enroll with the fiscal agent and be assigned a provider number for each office location. Each claim filed constitutes a contract with the Alabama Medicaid Agency, and represents that the services provided and fees charged are usual and customary by community standards and payment.

(3) Dental Services are defined as any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a dentist licensed to practice in the state the service is provided. Such services include treatment of the teeth and the associated structures of the oral cavity, and of disease, injury, or impairment which may affect the oral or general health of the individual. Such services shall maintain a high standard of quality and shall be within the reasonable limits of those services which are customarily available and provided to most persons in the community.

(4) Patient Identification

(a) The Alabama Medicaid Agency issues a plastic Medicaid Eligibility Card to persons when they are first eligible for benefits.

(b) The provider must verify eligibility through the fiscal agent office. The recipient or responsible adult is required to present this card with some form of identification when requesting services.

(c) It is most important that a provider's staff verify a Medicaid recipient's eligibility, since claims submitted on ineligible persons cannot be paid by Medicaid.

(d) Chapter One, General, Alabama Medicaid Agency Administrative Code, contains information about the identification of Medicaid recipients.

(5) Providers who agree to accept Medicaid payment must agree to do so for all covered services rendered during a particular visit. The dentist agrees when billing Medicaid for a covered service that the dentist will accept as payment in full the amount paid by Medicaid for that service and that no additional charge will be made. Providers may not bill Medicaid recipients they have accepted as patients for covered services. The dentist shall not charge or bill the recipient for cancelled or missed appointments. Conditional collections from patients made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible. The dentist may bill the patient for services rendered in the following circumstances:

(a) when benefits are exhausted for the set limit or
(b) when the service is a Medicaid non-covered benefit.

Refer to Chapter One, General, Alabama Medicaid Agency Administrative Code, for further information regarding Provider Rights and Responsibilities.

Author: Tina Edwards, Dental Program
Statutory Authority: State Plan, Attachment 3.1-A, page 1.2, 4.b (4); Title XIX, Social Security Act; 42 C.F.R. Section 441.57.
History: Rule effective October 1, 1982; April 12, 1984; June 8, 1985; December 1, 1986; March 12, 1987; April 1, 1991; June 12, 1991; January 13, 1993. **Amended**: Filed July 20, 2000; effective October 11, 2000. **Amended**: Filed March 22, 2004; effective June 16, 2004.

Rule No. 560-X-15-.02. Covered Dental Services.

A listing of the covered dental procedures and their limitations are included in the Alabama Medicaid Provider Manual, Chapter 13, which is provided by the fiscal agent.

Author: Tina Edwards, Dental Program
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq.
History: Rule effective October 1, 1982; April 1, 1991. **Amended**: Filed July 20, 2000; effective October 11, 2000. **Amended**: Filed March 22, 2004; effective June 16, 2004.

Rule No. 560-X-15-.03. Limitations.

(1) Dental care is limited to Medicaid eligible individuals who are under age 21 and are eligible for treatment under the EPSDT Program. Complete details on coverage limitations are contained in Chapter 13 of the Alabama Medicaid Provider Manual. Below are general guidelines.

(2) Dental care under this Program is available either as a result of the EPSDT Referral or as a result of request/need by the recipient. Conditions for each situation are as follows:

(a) EPSDT Referral. If the EPSDT Screening Provider determines a recipient requires dental care or if the recipient is 3 years of age or older and is not currently under the care of a dentist, the recipient must be referred to an enrolled dentist for diagnosis and/or treatment. After the recipient's dental care is initiated, the Consultant's portion of the general referral form must be completed by the dentist and the appropriate copy must be returned to the screening provider.

(b) Recipient Seeking Treatment. If a recipient who has not been screened through the EPSDT Program requests dental care, care may be provided without having an EPSDT Referral. In this situation, after the required care is completed, the dentist should advise the recipient to seek an EPSDT provider to obtain a complete medical assessment.

(3) A periodic oral examination is limited to once every six months for eligible Medicaid recipients under age 21.

(4) Dental sealants are covered by Medicaid, and are limited to one application per tooth in a recipient's lifetime. Refer to Chapter 13 of the Alabama Medicaid Provider Manual for specific limitations.

(5) Orthodontia is covered by Medicaid and is limited to medically necessary orthodontic services for eligible and qualified recipients. The services must be provided as a continuation of treatment initiated through multidisciplinary clinics administered by Alabama Children's Rehabilitation Service or other qualified clinics enrolled in the Medicaid Dental Program as a contract vendor. All medically necessary orthodontic treatment must be prior authorized by Medicaid.

(6) Radiological procedures are limited to those required to make a diagnosis. The radiographs should show all areas where treatment is anticipated. All x-ray films must be properly mounted suitable for interpretation and identification, with the patient's name, date, name of dentist, and marked "left" and "right". Specific limitations are outlined in Chapter 13 of the Alabama Medicaid Provider Manual.

Author: Tina Edwards, Dental Program
Statutory Authority: State Plan, Attachment 3.1-A, page 1.2, 4.b (4); Title XIX, Social Security Act; 42 C.F.R. Section 441.57.
History: Rule effective October 1, 1982; June 8, 1985; December 1, 1986; March 12, 1987; March 10, 1987; June 10, 1987; April 1, 1988; June 10, 1988; February 9, 1989; March 14, 1989; July 1, 1989; April

1, 1991; June 12, 1991; April 14, 1992. **Amended**: Filed July 20, 2000; effective October 11, 2000. **Amended**: Filed March 22, 2004; effective June 16, 2004.

Rule No. 560-X-15-.04. Reserved

Rule No. 560-X-15-.05. Prior Authorization.

(1) Certain services require prior authorization. Refer to Chapter 13 of the Alabama Medicaid Provider Manual.

Author: Tina Edwards, Dental Program
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq.
History: Rule effective October 1, 1982; May 9, 1984; January 8, 1985; August 9, 1985; April 1, 1991; June 12, 1991; January 13, 1993. **Amended**: Filed July 20, 2000; effective October 11, 2000. **Amended**: Filed March 22, 2004; effective June 16, 2004.

Rule No. 560-X-15-.06. Participation Requirements.

(1) Dental clinics administered by the Alabama Department of Public Health may participate in the program if they are approved by and enter into a vendor agreement (contract) with Medicaid. Providers who meet the Alabama Medicaid Agency enrollment requirements are eligible to participate in the Alabama Medicaid Program. An enrollment application may be requested from the Medicaid fiscal agent or downloaded from the Medicaid website at www.medicaid.state.al.us. Completed enrollment applications should be returned to Provider Enrollment at the address indicated on the form. Providers must complete an enrollment or an additional location enrollment application for each practice location.

(2) The Alabama Medicaid Agency will make payment for services to licensed, enrolled dental providers. All providers must meet the requirements to practice dentistry as set forth by the Alabama Dental Practice Act, Ala. Code Section 34-9-6.

(3) In accordance with federal law, Medicaid providers shall ensure that no person will, on the grounds of race, color, creed, national origin, age or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by the Agency. Compliance with Federal Civil Rights and Rehabilitation Acts is required of a provider participating in the Alabama Medicaid Program.

(4) Direct payments are made for allowable charges to providers for covered medical services and supplies furnished eligible Medicaid recipients.

(5) Refer to Chapter 20 concerning third party insurance carriers.

Author: Tina Edwards, Dental Program
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 400,100, 441.56.
History: Rule effective October 1, 1982; March 14, 1989; July 1, 1989; April 1, 1991; June 12, 1991; April 14, 1992. **Amended**: Filed July 20, 2000; effective October 11, 2000. **Amended**: Filed March 22, 2004; effective June 16, 2004.

Rule No. 560-X-15-.07. Assuring High Quality Care.

(1) Under the provisions of Federal and State law, Medicaid must establish a mechanism to insure that all such care is of good quality and that service(s) for which billing was made conforms to that which was done. See Chapter 2, Rule No. 560-X-2-.01. (2)(b) and (3) for criteria.

Author: Tina Edwards, Dental Program
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq.
History: Rule effective October 1, 1982. **Amended**: Filed March 22, 2004; effective June 16, 2004.

Rule No. 560-X-15-.08. Submitted Charges.

(1) Fees submitted shall not exceed usual, customary, and reasonable rates paid by the non-Medicaid population of the community. Participating dentists will be reimbursed by Medicaid for covered dental services. Providers should bill their usual and customary fees for dental services.

(2) The provider shall not charge Medicaid for services rendered on a no-charge basis to the general public.

(3) If the provider offers discounts or rebate to the general public, a like amount shall be adjusted to the credit of Medicaid on the Medicaid claim form, or such other method as Medicaid may prescribe.

(4) Orthodontic services provided as a continuation of treatment initiated through multidisciplinary clinics administered by Alabama Children's Rehabilitation Service (CRS) or other qualified multidisciplinary clinics are reimbursable if the clinics are approved by and enter into a vendor agreement (contract) with Medicaid. Fees paid for the services shall not exceed the reasonable rates established in the Medicaid statewide profile for medically necessary orthodontic services.

Author: Tina Edwards, Dental Program
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR Section 401, et seq.
History: Effective date of this emergency rule is April 1, 1991. Effective date of this amendment is June 12, 1991. **Amended**: Filed March 22, 2004; effective June 16, 2004.

Rule No. 560-X-15-.09. Mobile Dental Clinics.

(1) A mobile dental facility or portable dental operation (Mobile Dental Clinic) is any self-contained facility in which dentistry or dental hygiene is practiced which may be moved, towed, or transported from one location to another.

(2) Mobile Dental Clinics shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, Code of Federal Regulations and applicable Medicaid billing manuals.

(3) In order to enroll as a Mobile Dental Clinic, an operator shall:
(a) obtain a certificate of registration issued by the Board of Dental Examiners (the Board); and
(b) complete an Alabama Medicaid Provider Enrollment application.

(4) Mobile Dental Clinics shall comply with the following consent requirements:
(a) The operator of a Mobile Dental Clinic shall not perform services on a minor without the signed consent from the parent or guardian. The consent form shall be established by the Board.

(b) The consent form shall inquire whether the prospective patient has received dental care from a licensed dentist within one year and if so, the consent form shall request the name, address, and phone number of the dental home. If the information provided to the operator does not identify a dental home for the prospective patient, the operator shall contact the Alabama Medicaid Agency for assistance in identifying a dental home for Medicaid eligible patients. If this information is provided to the operator, the operator shall contact the designated dental home by phone, facsimile, or electronic mail and notify the dental home of the prospective patient's interest in receiving dental care from the operator. If the dental home confirms that an appointment for the prospective patient is scheduled with the dentist, the operator shall encourage the prospective patient or his or her guardian to seek care from the dental home.

(c) The consent form shall document that the patient, or legal guardian, understands the prospective patient has an option to receive dental care from either the Mobile Dental Clinic or his or her designated dental home if applicable.

(d) The consent form shall require the signature of a parent or legal guardian.

(5) Each Mobile Dental Clinic shall maintain a written or electronic record detailing all of the following information for each location where services are performed:

(a) The street address of the service location.

(b) The dates of each session.

(c) The number of patients served.

(d) The types of dental services provided and the quantity of each service provided.

(e) Any other information requested by rule of the Board or Medicaid.

(6) At the conclusion of each patient's visit to the Mobile Dental Clinic, the patient shall be provided with a patient information sheet which shall also be provided to any individual or entity to whom the patient has consented or authorized to receive or access the patient's records. The information sheet shall include at a minimum the following information:

(a) The name of the dentist or dental hygienist, or both, who performed the services.

(b) A description of the treatment rendered, including billing service codes and fees associated with treatment and tooth numbers when appropriate.

(c) If applicable, the name, address, and telephone number of any dentist to whom the patient was referred for follow-up care and the reason for such referral.

(d) The name, address, and telephone number, if applicable, of a parent or guardian of the patient.

(7) Mobile Dental Clinics shall comply with the following requirements for Emergency Follow-up Care:

(a) The operator shall maintain a written procedure for emergency follow-up care for patients treated in a Mobile Dental Clinic, which includes arrangements for treatment and follow-up care by a qualified dentist in a dental facility that is permanently established within a 50-mile radius of where mobile services are provided.

(b) An operator who either is unable to identify a qualified dentist in the area or is unable to arrange for emergency follow-up care for patients otherwise shall be obligated to provide the necessary follow up via the Mobile Dental Clinic or the operator may choose to provide the follow-up care at his or her established dental practice location in the state or at any other established dental practice in the state which agrees to accept the patient.

(c) An operator who fails to arrange or provide follow-up care as required herein shall be considered to have abandoned the patient, and will subject the operator and any dentist or dental hygienist, or both, who fail to provide the referenced follow-up treatment to termination as a Medicaid provider.

(8) The provider shall not charge Medicaid for services rendered on a no-charge basis to the general public.

(9) A Mobile Dental Clinic that accepts or treats a patient but does not refer patients for follow-up treatment when such follow-up treatment is clearly necessary, shall be considered to have abandoned the patient and will subject the operator and any dentist or dental hygienist, or both, who fails to provide the referenced follow-up treatment to termination as a Medicaid provider.

(10) Mobile Dental Clinics shall comply with the following requirements for sale or cessation of operation:

(a) In the event a Mobile Dental Clinic is to be sold, the current provider shall inform the Board and Medicaid, at least 10 days prior to the sale being completed and shall disclose the purchaser to the Board and Medicaid, via certified mail within 10 days after the date the sale is finalized.

(b) The provider shall notify the Board and Medicaid, at least 30 days prior to cessation of operation. Such notification shall include the final day of operation, and a copy of the notification shall be sent to all patients and shall include the manner and procedure by which patients may obtain their records or transfer those records to another dentist.

(c) It is the responsibility of the provider to take all necessary action to ensure that the patient records are available to the patient, a duly authorized representative of the patient, or a subsequent treating dentist. For purposes of this subsection, a patient shall mean any individual who has received any treatment or consultation of any kind within two years of the last date of operation of the Mobile Dental Clinic.

Author: Leigh Ann Hixon, Dental Program
Statutory Authority: State Plan Attachment 4.19-B; Title XIX, Social Security Act; 42 CFR Section 440.100; Alabama Act No. 2008-279.
History: New Rule: Filed June 20, 2008; effective September15, 2008.

Chapter 16 - Pharmaceutical Services

Rule No. 560-X-16-.01- Pharmacy Services - General.

(1) The State Plan provides for the payment of certain legend and non-legend drugs prescribed by Doctors of Medicine, and other practitioners including, but not limited to nurse practitioners, dentists, and physician assistants who are legally authorized to prescribe these drugs and when dispensed and/or administered by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws.

(2) In accordance with the Medicaid Drug Amendments contained in the Omnibus Budget Reconciliation Act of 1990, (Public Law 101-508), the following shall apply: with the exception of allowable published exclusions, only those drugs manufactured by companies having signed rebate agreements with the Secretary of Health and Human Services are compensable. The exclusions are:

(a) DESI and IRS drugs which may be restricted in accordance with Section 1927(d)(2) of the Social Security Act

(b) Agents when used for anorexia, weight loss, or weight gain except for those specified by the Alabama Medicaid Agency

(c) Agents when used to promote fertility except for those specified by the Alabama Medicaid Agency

(d) Agents when used for cosmetic purposes or hair growth except for those specified by the Alabama Medicaid Agency

(e) Agents when used for the symptomatic relief of cough and cold except for those specified by the Alabama Medicaid Agency

(f) Agents when used to promote smoking cessation, unless authorized for pregnant females.

(g) Prescription vitamin and mineral products, except prenatal vitamins and fluoride preparations and others as specified by the Alabama Medicaid Agency

(h) Nonprescription drugs except for those specified by the Alabama Medicaid Agency

(i) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated test or monitoring services be purchased exclusively from the manufacturer or its designee

(j) Barbiturates and benzodiazepines except for those specified by the Alabama Medicaid Agency

(k) Agents when used for the treatment of sexual or erectile dysfunction, unless authorized for medical necessity.

(3) Medicaid will pay for approved drug items when they are properly prescribed for eligible Medicaid recipients.

(4) Telephone prescriptions are not allowed for Schedule II controlled substances. The pharmacist must obtain an original prescription and maintain that documentation on file. EXCEPTION: In accordance with Alabama pharmacy law, Controlled Substances Act, §20-2-58(c), a prescription written for Schedule II substances for a resident of a long-term care facility may be transmitted by the practitioner or the agent of the practitioner to the dispensing pharmacy by facsimile. The facsimile shall serve as the original written prescription.

(5) The pharmacist initiates a two part Medicaid Pharmacy Claim. The original part of the claim must be retained by the pharmacy for State and audit purposes, and the duplicate is submitted to the fiscal agent for payment. Claims for services may be filed electronically if the provider has signed an electronic claim agreement with the Alabama Medicaid Agency.

(6) Eligible recipients have freedom of choice in the selection of a pharmacy that has a current Pharmacy Vendor Agreement, and must be accorded the same courtesies and services rendered to all other patrons of the pharmacy.

(7) Title XIX (Medicaid) prescriptions should be written and dated for either legend or over-the-counter drugs. Signatures by the prescribing physician are required on all prescriptions for Schedule II drugs. Stamped or typewritten signatures are not acceptable. Schedule II drugs may not be dispensed to Medicaid recipients without an original prescription. Therefore, call-in prescriptions are not acceptable for Schedule II drugs. Telephone prescriptions for non-controlled drugs and drugs other than Schedule II drugs are acceptable without subsequent signature of the practitioner. EXCEPTION: In accordance with Alabama pharmacy law, Controlled Substances Act, §20-2-58(c), a prescription written for Schedule II substances for a resident of a long-term care facility may be transmitted by the practitioner or the agent of the practitioner to the dispensing pharmacy by facsimile. The facsimile shall serve as the original written prescription.

(a) Effective April 1, 2008, all prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads. The term “written prescription” does not include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy, or prescriptions communicated to the pharmacy by telephone by a prescriber. This requirement does not apply to refills of written prescriptions which were executed before April 1, 2008. It also does not apply to drugs provided in nursing facilities, intermediate care facilities for the mentally retarded, and other institutional and clinical settings to the extent the drugs are reimbursed as part of a per diem amount, or where the order for a drug is written into the medical record and the order is given directly to the pharmacy by the facility medical staff.

1. If a written prescription is received which is not on a tamper-resistant prescription blank, the pharmacy must contact the prescribing provider and either have the prescription re-submitted in compliant written form or convert the prescription, where otherwise allowable, into verbal, faxed or electronic form.

2. In an emergency situation where the pharmacy is unable to contact the prescribing provider, the pharmacy may choose to fill the prescription from the non-compliant form and subsequently obtain a prescription in compliant form. If a compliant prescription cannot be obtained within 72 hours, the pharmacy must withdraw the claim.

3. To be considered tamper-resistant on or after April 1, 2008, a prescription pad must contain at least one of the following three characteristics:

(i) one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; or

(ii) one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or

(iii) one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

4. To be considered tamper-resistant on or after October 1, 2008, a prescription pad must contain all of the foregoing three characteristics.

(8) Pharmacies shall use the correct physician license number when submitting a pharmacy claim to Medicaid.

(9) Pharmacies should not dispense refill medication to recipients until such time that the designated amount of the original prescription has been utilized. For quantities up to a 34 day supply, the designated amount is 75% of the original days' supply. For quantities greater than a 34 day supply, the designated amount is 90% of the original days' supply. Pharmacists must have documentation on the original prescription that the prescribing physician was consulted and the physician approved. Payments for early refills may be recouped by the Medicaid Agency.

(10) Pharmacies receiving hard denials such as early refill, therapeutic duplication and excessive quantity must receive an override from Medicaid or its designated agent before payment will be made.

(11) Any changes to the original prescription, such as physician approved changes in dosage, should be documented on the original prescription.

(12) A provider agrees to accept as payment in full the amount paid by the State, plus any cost-sharing amount to be paid by the recipient, for covered items, and further agrees to make no additional charge or charges for covered item to the recipient, sponsor, or family of the recipient. However, a provider may bill the recipient for the appropriate allowable copayment amount.

(13) The provider may refuse to accept Medicaid for a Medicaid-covered item and bill the recipient as a regular paying patron if the recipient is informed prior to dispensing the prescription. The recipient has the right to have the prescription filled by any other authorized Medicaid provider.

Author: Bakeba R. Thomas, Associate Director, Pharmacy Clinical Support.
Statutory Authority: State Plan Attachment 3.1-A and 4.18-B; Title XIX, Social Security Act; 42 CFR Section 447.15, 447.331 & Section 401, et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), and Public Law 110-28 (SSA Sec. 1903(i)).
History: Rule effective October 1, 1982. Amended July 8, 1983; March 12, 1984; July 9, 1984; June 8, 1985; April 11, 1986; November 10, 1987; April 14, 1992; March 13, 1993; January 1, 1994; March 15, 1994; April 12, 1996; February 11, 1997; November 12, 1997; February 10, 1998; and June 10, 1999. **Amended:** Filed December 19, 2005; effective March 17, 2006. **Amended:** Filed March 20, 2006; effective June 16, 2006. **Amended:** Emergency Rule filed and effective April 1, 2008. **Amended:** Filed April 21, 2008; effective July 16, 2008. **Amended:** Filed October 20, 2009; effective January 15, 2010. **Amended:** Emergency Rule filed and effective November 2, 2009. **Amended:** Filed November 18, 2009; effective February 15, 2010. **Amended:** Filed November 19, 2010; effective March 1, 2011.

Rule No. 560-X-16-.02. Requirements for Participation.

(1) A pharmacy must be operating under a permit or license to dispense drugs as issued by the Alabama State Board of Pharmacy or appropriate authority in the State where the service is rendered.

(2) A pharmacy applicant must submit and have approved a pharmacy agreement signed by owner, authorized representative, pharmacist, or dispensing physician.

(3) Pharmacies and dispensing physicians must agree to abide by the rules and regulations of the program; must agree that payment for covered services will be accepted as payment in full.

(4) Pharmacy providers must agree to abide by the rules and regulations of third party billing procedures (See Chapter 20 Third Party).

(5) Pharmacy providers must agree to keep records, including prescriptions, to fully disclose extent of services rendered. Records, including purchase invoices, recipient signature logs, etc., should be maintained within the State of Alabama. At a minimum the following records and/or documentation must be available for examination: (1) prescription files and (2) invoices.

(6) Pharmacy providers must agree that the Alabama Medicaid Agency or its representative may conduct audits of required records as necessary. Invoice records must be maintained and be readily available for inspection. If, due to the location of the provider's records, Medicaid personnel are required to go out of state for an audit, the organization being audited will bear all expenses and costs related to the audit, including, but not limited to, travel and reasonable living expenses.

(7) All Medicaid participating pharmacies must be in compliance with Title VI and VII of the Civil Rights Act of 1964 and with Section 504 of the Rehabilitation Act of 1973.

Authority: State Plan Attachment 3.1A and 4.18B; Title XIX, Social Security Act; 42 C.F.R. Section 447.331 & Section 401, Et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Rule effective October 1, 1982. Amended October 7, 1983 and April 14, 1992. Amended March 15, 1994. Amended November 12, 1997. Effective date of this amendment is February 10, 1998.

Rule No. 560-X-16-.03. Drugs Dispensed by a Physician

(1) A physician may dispense drugs under the Alabama Medicaid Program if he has a current agreement to dispense drugs with the Alabama Medicaid Agency.

(2) Dispensing physicians are enrolled as drug providers in the Pharmacy Program only where adequate pharmacy services are not available.

(3) A dispensing physician may be enrolled as a drug provider in the Pharmacy Program only if his practice is located more than 50 miles or 50 minutes from the nearest Medicaid-enrolled pharmacy.

Author: Lynn Sharp, Associate Director, Policy Development Unit.
Statutory Authority: State Plan, Attachment 3.1-A and 4.19-B; Title XIX, Social Security Act; 42 CFR, Section 447.331 and Section 401; et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).

History: Rule effective October 1, 1982. Amended April 14, 1992. Amended: Filed August 20, 1999; effective November 10, 1999.

Rule No. 560-X-16-.04. Pharmacy Services in Hospitals.

(1) Hospitals. Payment for drugs for inpatient hospital care under the Title XIX Program is based on reasonable cost which allows payment (per diem) not to exceed Medicare levels.

Authority: State Plan Attachment 3.1A and 4.18B; Title XIX, Social Security Act; 42 C.F.R. Section 447.331 & Section 40l,Et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Rule effective October 1, 1982. Rule amended April 14, 1992. Amended November 12, 1997. Effective date of this amendment is February 10, 1998.

Rule No. 560-X-16-.05 Long Term Care Facilities.

(1) (a) The nursing facility must meet the State and Federal Standards and the Title XIX rules and regulations for pharmacy services.

(b) The payment limit for prescription drugs dispensed to patients confined in the Long Term Care facilities must not exceed the upper limits as contained in Rule 560-X-16-.06.

(2) Over-the-counter insulins, covered through the Medicaid pharmacy program may be submitted for payment by utilizing the NDC number. All other OTC medications/products should be included in the facility cost report. See Rule No. 560-X-16-.12.

(3) Payment for drugs dispensed with a unit dose system will be limited to those pharmacies that make application and are approved by the Medicaid Pharmacy Program.

(4) As an attachment to or included with such application, the pharmacy must include a detailed explanation of the delivery system employed to provide drugs to the nursing facility.

(5) The furnishing of solid oral dosage form of a covered drug item by an approved unit dose system is an acceptable method for providing drugs under the program.

(6) The basis of payment for the unit dose drug distribution system cannot exceed the upper limits of payment as set forth by the regulations.

(7) The Alabama Medicaid Agency requires that all prescriptions for Medicaid nursing home patients who are on long-term therapy or maintenance drugs be written for a 30 up to a 34-day supply. A 90-day supply is permitted for certain maintenance therapies. Payment for units greater than 34 days, unless otherwise permitted, may be recouped by Medicaid unless the pharmacist can provide documentation to support the units dispensed. EXCEPTION: This requirement does not apply to those pharmacies that are utilizing a unit dose system approved by the Alabama Medicaid Agency.

(8) Each pharmacy using an approved unit dose system must submit only one claim per drug per recipient each month and only the amount of the prescribed drug actually consumed by the patient may be included.

(9) All medication orders are filled and/or dispensed from a signed original or direct copy of the physician's prescription order as authorization for approved unit dose pharmacies. Exception: Telephoned prescriptions for non-controlled drugs are acceptable without the subsequent signature of the practitioner.

(10) Each dose is individually packaged in a sealed, tamper proof container and carries full disclosure labeling, including, but not limited to, product name and strength, manufacturer's or distributor's name, lot number and expiration date.

(11) When a resident leaves the facility and is expected to return, a facility shall hold all medications until the return of the resident. All continued or re-ordered medications will be placed in active medication cycles upon the return of the resident. If the resident does not return to the facility within 30 days, any medications held by the facility shall be placed with other medications for destruction or distribution as permitted by the State Board of Pharmacy regulations. If at the time of discharge it is known that the patient will not return, medications may be destroyed or donated as allowed by State law.

Author: Bakeba R. Thomas, Associate Director, Pharmacy Clinical Support.
Statutory Authority: State Plan, Attachment 3.1-A and 4.19-B; Title XIX, Social Security Act; 42 C.F.R. Section 447.331 & Section 401, et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).
History: Rule effective October 1, 1982. Amended April 14, 1992; November 12, 1997; and February 10, 1998. **Amended:** Filed March 19, 1999; effective June 10, 1999. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed April 20, 2005; effective July 15, 2005. **Amended:** Filed November 19, 2010; effective March1, 2011.

Rule No. 560-X-16-.06. Reimbursement for Covered Drugs and Services.

(1) Medicaid pays for certain legend and non-legend drugs prescribed by practitioners legally licensed by the state of Alabama to prescribe the drugs authorized under the program and dispensed and/or administered by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws as stated in Rule 560-X-16-.01.

(2) Multiple Source Drugs. Reimbursement for covered multiple source drugs in the Medicaid Program shall not exceed the lowest of:

(a) The federally mandated upper limit (FUL) for certain multiple source drugs as established and published by CMS plus a reasonable dispensing fee as discussed in paragraph (6) below; or

(b) The Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee. AEAC is defined by Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, the Wholesale Acquisition Cost (WAC) + 9.2%; or

(c) The provider's Usual and Customary charge to the general public for the drug; or

(d) The Alabama State Maximum Allowable Cost (State MAC) plus a reasonable dispensing fee. The State MAC is defined as the AAC of a drug multiplied by at least 1.0 that will apply to all multiple source drugs within a particular grouping. The State MAC reimbursement will apply to certain multiple source drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Alabama Medicaid Agency. Reimbursement methodology for the State MAC shall be as follows:

- Drugs are subject to a State MAC if there is at least one non-innovator multiple source alternative product available.
- The Alabama Medicaid Agency or its designated representative will collect and review pharmacy invoices and other information deemed necessary by the Alabama Medicaid Agency in an effort to determine AAC in accordance with applicable State and Federal law.
- This information will be collected from Medicaid-participating pharmacies via surveys. The AAC is multiplied by at least 1.0 to derive the State MAC rate that will apply to all multiple source drugs within the particular grouping.
- The Alabama Medicaid Agency will periodically review the rates and adjust them as necessary to reflect the Alabama Medicaid Agency's understanding of prevailing market conditions.

EXCEPTION: The FUL and/or State MAC may be waived for a brand innovator multiple-source drug. For these cases the prescriber must provide documentation of the medical necessity for the brand name rather than the available generic equivalent and receive an override.

(3) Other Drugs. Reimbursement for covered drugs other than multiple source drugs shall not exceed the lower of:

(a) The Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee. AEAC is defined by Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, the Wholesale Acquisition Cost (WAC) + 9.2%; or

(b) The provider's Usual and Customary charge to the general public for the drug; or

(c) For blood clotting factor products, Medicare Part B Drug pricing plus a reasonable dispensing fee.

(4) Blood clotting factor products. In addition to providing blood clotting factor, providers of the Alabama Medicaid Agency are required to provide, at the minimum, clinically appropriate items and services to their hemophilia patients as outlined in Rule No. 560-X-16-.31.

(5) The pharmacist shall submit claims in the units specified on the prescription by the prescribing physician up to a 34-day supply. A 90-day supply is permitted for certain maintenance therapies. Payment for units greater than 34 days, unless otherwise permitted, may be recouped by Medicaid unless the pharmacist can provide documentation to support the units dispensed. Medications supplied in a dosage form that would prevent the dispensing of an exact 30 up to a 34-day supply for chronic medications, such as insulin, may require quantities that exceed the 34-day maximum and would not be subject to recoupment as long as the pharmacist can provide appropriate documentation.

(6) Dispensing Fees. A reasonable dispensing fee is set by the Agency. This fee is reviewed periodically for reasonableness and, when deemed appropriate by Medicaid, may be adjusted.

(7) Unless the designated amount of the original days' supply has been utilized or there is a documented consultation with the prescribing physician, only one dispensing fee is allowed for a 30 up to a 34-day supply of the same drug per month. For quantities up to a 34-day supply, the designated amount is 75% of the original days' supply. For quantities greater than a 34-day supply, the designated amount is 90% of the original days' supply.

(8) The Veterans Health Care Act of 1992 enacted section 340 B of the Public Health Services Act, "Limitation on Prices of Drugs Purchased by Covered Entities". This Section provides that a manufacturer who sells covered outpatient drugs to eligible entities must sign a pharmaceutical pricing agreement with the Secretary of Health and Human Services in which the manufacturer agrees to charge to Medicaid a price for covered outpatient drugs that will not exceed the average manufacturer price decreased by a rebate percentage.

(a) Eligible entities are as follows:

1. Federally qualified health centers.
2. Health centers for residents of public housing funded under section 340A of the Public Health Services Act, (42 U.S.C. 256a.)
3. Family planning projects received grants or contracts under section 1001 of the Public Health Services Act, (42 U.S.C. 300.)
4. An entity receiving a grant for outpatient early intervention services for HIV disease under subpart II of part C of title XXVI of the Public Health Services Act, (42 U.S.C. 300ff -51 et seq.)
5. A State-operated AIDS drug purchasing assistance program receiving financial assistance.
6. A black lung clinic receiving funds.
7. A comprehensive hemophilia diagnostic treatment center receiving a grant.
8. A native Hawaiian Health Center receiving funds.
9. An urban Indian organization receiving funds.
10. Any entity, certified by the Secretary, receiving assistance under title XXVI of the Public Health Services Act, (42 U.S.C. 300ff et seq.)
11. Any entity, certified by the Secretary, receiving funds relating in the treatment of sexually transmitted disease.
12. A "disproportionate share" hospital as defined in section 1886 (d)(1)(B) of the Social Security Act.

(b) When an eligible entity submits a bill to the Medicaid Agency for a drug purchase by or on behalf of a Medicaid recipient, the amount billed shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus the dispensing fee established by the Medicaid Agency. Covered entities are identified to Medicaid by the Department of Health and Human Service. These entities will be notified by Medicaid of their designation as a Veteran's Health Care Act provider. These providers are required to bill at actual invoice cost plus dispensing fee. As manufacturer price changes occur, providers must ensure that their billings are updated accordingly.

(c) Audits of the eligible entities' claims submissions and invoices will be conducted by the Medicaid Agency. Providers must be able to verify acquisition costs through review of actual invoices for the time frame specified. Charges to Medicaid in excess of the actual invoice costs will be subject to recoupment by the Medicaid Agency.

(9) Medicaid may reimburse for professional services provided by licensed pharmacists. Professional services may include vaccine administration, medication maintenance therapy adherence and other clinical services as designated by the Agency.

Author: Bakeba R. Thomas, Associate Director, Pharmacy Clinical Support.
Statutory Authority: State Plan, Attachment 3.1-A and 4.19-B; Title XIX, Social Security Act; 42 CFR Section 447.205 & Section 447.331; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508); Veterans Health Care Act of 1992 (Public Law 102-585).
History: Rule effective October 1, 1982. **Amended:** October 29, 1987: December 10, 1987; April 14, 1992; November 12, 1993; April 12, 1996; November 12, 1997; and February 10, 1998. **Amended:** Filed March 19, 1999; Effective June 10, 1999. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed April 20, 2005; effective July 15, 2005. **Amended:** Filed July 20, 2007; effective December 14, 2007. **Amended:** Filed January 22, 2008; effective May 1, 2008. **Amended:** Emergency Rule filed and effective November 2, 2009. **Amended:** Filed November 18, 2009; effective February 15, 2010. **Amended:** Filed May 20, 2010; effective August 13, 2010. **Amended:** Filed November 19, 2010; effective March 1, 2011.

Rule No. 560-X-16-.07 Out-of-State Pharmacies.

(1) Under State and Federal regulations, a pharmacy must sign an agreement with Alabama Medicaid Agency. However, when a recipient is in another state and requires service, the following procedure has been adopted.

(2) Pharmacies Bordering Alabama

(a) Pharmacies bordering Alabama may participate in the Alabama Medicaid Program by completing an application for out-of-state pharmacies, and upon certification of the State Board of Pharmacy in that state that the pharmacy is registered and has been issued a permit.

(b) The pharmacy must then sign a Pharmacy Vendor Agreement with Alabama Medicaid Agency and agree to abide by the State pharmacy provider tax law.

(c) Pharmacies bordering Alabama are defined as those pharmacies located not more than 30 miles from the border of Alabama.

(3) Pharmacies Not Bordering Alabama

(a) Drugs dispensed must be in concurrence with the limitations in place for in-state providers.

(b) Reimbursement will be made only for hemophilia products and specialty drugs which are not readily available in-state, and drugs dispensed to Medicaid recipients who may be traveling outside the state of Alabama.

(c) Providers of specialty drugs shall list the names of the drugs for which they intend to request reimbursement as well as the GCN or NDC numbers for each drug in the letter requesting enrollment with the Alabama Medicaid Agency.

(d) Pharmacies not bordering Alabama will be enrolled by the Medicaid fiscal agent on a temporary basis.

(e) Pharmacies not bordering Alabama are defined as those pharmacies located more than 30 miles from the border of Alabama.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan, Attachment 3.1A and 4.19B; Title XIX, Social Security Act; 42 CFR, Section 447.331, Section 401, Et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).
History: Rule effective October 1, 1982. Amended June 8, 1984; April 14, 1992; November 12, 1997; and February 10, 1998. Amended: Filed April 20, 1999; effective July 13, 1999. Amended: Emergency rule filed and effective July 13, 1999. Amended: Filed October 20, 1999; effective January 12, 2000. Amended: Filed December 18, 2000; effective March 12, 2001.

Rule No. 560-X-16-.08. Injections.

(1) Injectable drugs administered by physicians and outpatient hospitals are allowable.

(2) Claims for injectable medication administered by the physician should be made on the Physician's Claim Form and submitted to the fiscal agent for payment.

(3) Claims for injectable medications administered in an outpatient hospital should be made on the UB-8 92 and submitted to the fiscal agent by the outpatient facility.

(4) For information concerning injectable medications administered in renal dialysis facilities, please refer to Rule No. 560-X-24-.05.

(5) The Medicaid Pharmacy Program will review and have final approval of injectable medications and the rate of reimbursement that is billed to the fiscal agent by the physician or outpatient hospital.

Authority: State Plan, Attachment 3.1A and 4.18B; Title XIX, Social Security Act; 42 C.F.R. Section 447.331 & Section 401, Et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Rule effective October 1, 1982. Amended May 9, 1984, November 10, 1987. Rule amended April 14, 1992. Amended November 12, 1997. Effective date of this amendment is February 10, 1998.

Rule No. 560-X-16-.09. Reserved.

Rule No. 560-X-16-.10. Cost-Sharing

(1) Medicaid recipients are required to pay the designated co-pay amount for each prescription filled and each refill.

(2) The cost-sharing fee does not apply to family planning drugs and supplies, or to drugs prescribed for recipients under 18 years of age, recipients who are in a nursing facility or services furnished to pregnant women.

(3) When a pharmacy fills a prescription for a Medicaid recipient under eighteen (18) years of age, the pharmacist must verify the age of the individual by checking the date of birth on the eligibility card. Co-payment on drug claims for family planning drugs and supplies will be determined by the national drug code numbers. No further indication is necessary on the claim form for a Medicaid recipient under eighteen (18) years of age or for claims submitted for family planning drugs and supplies.

(4) When a pharmacy fills a prescription for a Medicaid recipient residing in a nursing facility in Alabama the pharmacy provider must indicate a large "I" in the Co-pay block on the Medicaid Pharmacy Claim Form or appropriate space for other approved drug claim submission methods (i.e., continuous feed form, tape-to-tape, etc.).

(5) When a pharmacist dispenses a prescription for a Medicaid eligible woman on which the physician has written PREGNANT, the pharmacist shall place a "P" in the Co-pay block on the Medicaid Pharmacy Claim Form or appropriate space for other approved drug claim submission methods (i.e., continuous feed form, tape-to-tape, etc.).

(6) Copayment Collection: Copayment is based on drug ingredient cost of the dispensed prescription. The schedule is furnished by the Medicaid Agency Pharmacy Program.

(7) A provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount.

Authority: State Plan, Attachment 3.1A and 4.18B; Title XIX, Social Security Act; 42 C.F.R. Section 447.15, Section 447.53, & Section 447.331; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508). Rule effective October 1, 1982. Amended September 8, 1983, December 6, 1984 and June 8, 1985; Rule amended April 14, 1992. Amended November 12, 1997. Effective date of this amendment is February 10, 1998.

Rule No. 560-X-16-.11. Pharmacist Consultant Services in Nursing Facilities.

(1) Federal regulations require pharmacy consultant services in nursing facilities as a condition of participation. This requirement recognizes the professional status of the pharmacist and makes him an integral part of the health care team.

(2) The requirement that there be pharmacy consultant services is imposed on the facility as a condition of participation. Thus, compensation is appropriately an arrangement between the facility and the consultant.

Authority: State Plan, Attachment 3.1A and 4.18B; Title XIX, Social Security Act; 42 C.F.R. Section 447.331 and Section 401, Et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Rule effective October 1, 1982; Rule Amended April 14, 1992.

Rule No. 560-X-16-.12. Over-the-Counter Medications.

(1) Over-the-counter medications/products require a signed prescription from a physician or other practitioner legally licensed by the State of Alabama to prescribe the drugs authorized under the program.

(2) Over-the-counter medications/products must be dispensed by a licensed Medicaid pharmacist in accordance with state and federal laws as stated in Rule 560-X-16-.01.

(3) Over-the-counter medications/products will be reimbursed as stated in Rule No. 560-X-16-.06 Reimbursement for Covered Drugs.

(4) Over-the-counter medications/products will be covered in long term care facilities as stated in Rule No. 560-X-16-.05 Long Term Care Facilities.

Author: Stephanie Frawley, CPhT, Pharmacy Services.
Statutory Authority: State Plan, Attachment 3.1-A and 4.19-B; Title XIX, Social Security Act.
History: Rule effective February 11, 1997. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed April 20, 2005; effective July 15, 2005.

Rule No. 560-X-16-.13. Claim Form Acquisition.

The Medicaid fiscal agent will furnish claim forms upon request.

Authority: The Alabama Medicaid Agency Contract with Fiscal Agent for payment of claims. Rule effective October 1, 1982.

Rule No. 560-X-16-.14. Reserved.

Rule No. 560-X-16-.15. Claim Filing Limitations.

For claim filing limitations, refer to Chapter 1, Rule 560-X-1-.17.

Authority: State Plan, Attachment 3.1A; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq. Rule effective October 1, 1982. Effective date of this amendment November 11, 1985.

Rule No. 560-X-16-.16. Automated Billing System.

Refer to Rules 560-X-1-.17 and 560-X-1-.18.

Authority: State Plan, Attachment 3.1A; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq. Rule effective October 1, 1982. Effective date of this amendment March 12, 1988.

Rule No. 560-X-16-.17. Restriction of Recipients.

The recipient may be placed on restriction who has abused and/or over utilized pharmacy and/or physician services. The procedure to place an individual on restriction and limit the individual to a pharmacy and a physician is stated in Chapter 4 on S/UR in this Code.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq. Rule effective October 1, 1982.

Rule No. 560-X-16-.18. Pharmacy Peer Review Committees.

Composition and selection is as stated in Chapter 2 of this Code.

Authority: State Plan, Attachment 3.1A; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq. Rule effective October 1, 1982. Rule amended April 14, 1992.

Rule No. 560-X-16-.19. Pricing Information.

The Medicaid Physicians Program shall approve the rate of reimbursement for injectable drugs (for physicians or outpatient hospitals). The actual research and price determination is made by the fiscal agent as set forth in the fiscal agent contract. The drug pricing file is furnished to the fiscal agent who shall update and utilize for pharmacy claims processing within twenty-four (24) hours of receipt for pharmacy claims.

Authority: State Plan Attachment 3.1A and 4.18B; Title XIX, Social Security Act; 42 C.F.R. Section 447.331 and Section 401, Et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Rule effective October 1, 1982. Effective date of amendment May 9, 1984. Rule amended April 14, 1992. Amended November 12, 1997. Effective date of this amendment is February 10, 1998.

Rule No. 560-X-16-.20. Quantity Limitations.

(1) Prescriptions should be written to provide a sufficient amount of medication necessary for the duration of the illness or an amount sufficient to cover the interval between physician's visits. A 34-day supply shall not be split into small units and submitted as separate claims.

(2) The quantity for which a prescription is written should not exceed a maximum of eleven refills for non controlled prescriptions or five refills for Control III-V prescriptions. Claims for prescription refills beyond eleven refills for non controlled prescriptions or five refills for Control III-V prescriptions shall be denied.

(3) Quantities (units) of drugs prescribed by a physician shall not be arbitrarily changed by a pharmacist except by authorization of the physician.

(a) The pharmacist must contact the prescribing physician for authorization to reduce the quantity of any Medicaid prescription.

(b) Authorization to reduce the units of a prescription must be noted on the prescription form by the pharmacist.

(4) If the full quantity prescribed is not available at the time of dispensing, the pharmacist may dispense the quantity available. In this case the pharmacist is required to note on the prescription the number of units dispensed and retain the claim until the balance of medication is dispensed. The claim is then submitted with one dispensing fee. If more than one dispensing fee is received, recoupments may be initiated if the dispensing pharmacy cannot provide documentation to support why multiple dispensing fees were received within the same month.

(5) Medicaid patients regulated on long-term or maintenance drugs which require a systematic and routine dosage of thirty to thirty-four days or more should receive their drugs in quantities greater than the thirty to thirty-four-day supply.

(6) Maintenance medications are those generally used to treat chronic conditions or illnesses and are ordered/prescribed and taken regularly and continuously. Medicaid recipients can obtain a 90-day supply of maintenance medications as designated by the Agency. The patient must first have demonstrated stability for at least 60 days (same strength and dose) on a given maintenance medication. Only one co-pay is collected and only one dispensing fee is paid for the 90-day supply. A list of maintenance medications is available on the Medicaid website.

(7) Effective January 1, 2008, the number of outpatient pharmacy prescriptions for all recipients except as specified below is limited to five brand name drugs per month per recipient. In no case can total brand name prescriptions exceed ten per month per recipient. There is no limit on generic and covered over-the-counter prescriptions. Prescriptions for Medicaid eligible recipients under age 21 in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and prescriptions for Medicaid eligible nursing facility residents are excluded from these limitations.

(a) Brand name anti-psychotic and anti-retroviral agents may be paid up to ten prescriptions per month but in no case can total brand name prescriptions exceed ten per month per recipient.

(b) Effective November 22, 2004, coverage of up to ten brand name prescriptions per month may be allowed through overrides for drugs classified by American Hospital Formulary Services (AHFS) or First DataBank (FDB) Therapeutic Class as Antineoplastic Agents, Antiarrhythmic Agents, Cardiotonic Agents, Miscellaneous Vasodilating Agents, Miscellaneous Cardiac Agents, Nitrates and Nitrites, Alpha Adrenergic Blocking Agents, Beta Adrenergic Blocking Agents, Dihydropyridines, Miscellaneous Calcium Channel Blocking Agents, Diuretics, Angiotensin-Converting Enzyme Inhibitors, Angiotensin II Receptor Antagonists, Mineralocorticoid (Aldosterone) Receptor Antagonists, Central Alpha Agonists, Direct Vasodilators, Peripheral Adrenergic Inhibitors, Miscellaneous Hypotensive Agents,

Hemostatics, Calcium Replacements, Electrolyte Depleters, Immunosuppresives, Alpha Glucosidase Inhibitors, Amylinomimetics, Biguanides, Dipeptidyl Peptidase-4 Inhibitors, Incretin Mimetics, Insulins, Meglitinides, Sulfonylureas, Thiazolidinediones, and Miscellaneous Diabetic Agents. Overrides will be granted only in cases in which the prescribing physician documents medical necessity for the recipient to be switched from a product in one of the above named classes to a brand name product within the same therapeutic class in the same calendar month. The first product must have been covered by Medicaid.

Author: Bakeba R. Thomas, Associate Director, Pharmacy Clinical Support.
Statutory Authority: State Plan, Attachment 3.1-A; Title XIX, Social Security Act; 42 CFR Section 401, et seq.
History: Rule effective October 1, 1982: Amended December 6, 1984; November 10, 1987; April 14, 1992; November 12, 1997; and February 10, 1998. **Amended:** Filed March 22, 2004; effective June 18, 2004. **Amended:** Filed August 20, 2004; effective November 22, 2004. **Amended**: Filed August 22, 2005; effective November 16, 2005. **Amended:** Filed August 20, 2007; effective November 16, 2007. **Amended:** Filed November 19, 2010; effective March 1, 2011.

Rule No. 560-X-16-.21. Prescription Refill.

(1) Prescriptions will have a maximum of no more than eleven (11) refills for non controlled prescriptions or five (5) refills for Control III-V prescriptions authorized.

(2) Physicians are urged to designate refills or indicate non-refills on all Title XIX (Medicaid) prescriptions. If the physician does not designate refills or indicates no refill on the prescription, then the non-refill status will apply. If the physician grants oral authorization to refill a previously undesignated or non-refillable prescription, the pharmacist must indicate each authorization on the prescription.

(3) If a prescription is refilled, the date upon which the prescription is refilled must appear on the prescription.

(4) All prescriptions should be refilled only in quantities commensurate with dosage schedule and refill instructions.

(5) Violations of these policies may result in unauthorized charges for which the pharmacy may be held liable and/or cancellation of the pharmacy vendor agreement.

Author: Kelli Littlejohn, RPh, Director, Pharmacy Services
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR Section 401, et seq.
History: Rule effective October 1, 1982. Amended April 11, 1986, November 10, 1987, and April 14, 1992**. Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-16-.22. Signature Requirement for Manual Pharmacy Claim Form.

For recipient and provider signature requirements, please refer to Rule No. 560-X-1-.18.

Authority: State Plan, Attachment 3.1A and 4.18B; Title XIX, Social Security Act; 42 C.F.R. Section 447.331 and Section 401, Et seq.; Omnibus Budget Reconciliation Act of 1990 (Public

Law 101-508) Rule effective October 1, 1982. Amended November 10, 1987. Rule change April 14, 1992.

Rule No. 560-X-16.-23. Drug Utilization Review (DUR) - General.

In accordance with the Medicaid Drug Amendments contained in the Omnibus Budget Reconciliation Act of 1990, (Public Law 101-508), the following shall apply:

(1) The Medicaid Agency shall provide, by not later than January 1, 1993, for a Drug Utilization Review (DUR) Program for covered outpatient drugs in order to assure that prescriptions are appropriate, medically necessary, and are not likely to result in adverse medical results.

(2) The DUR Program is made up of the following components: Prospective Drug Utilization Review, Retrospective Drug Utilization Review, and an educational program.

(3) The Alabama Medicaid Agency has established a DUR Board. Board membership shall be composed of four practicing physicians, four practicing pharmacists, two representatives from the state's pharmacy schools, two representatives from the state's medical schools, and two representatives from the Alabama Medicaid Agency with knowledge and experience in:

(a) Clinically appropriate prescribing and dispensing of covered outpatient drugs
(b) Monitoring of covered outpatient drugs
(c) Drug use review, evaluation and intervention
(d) Medical quality assurance

(4) Physician and pharmacist DUR Board members must be licensed in Alabama.

(5) The activities of the DUR Board include:

(a) Retrospective DUR
(b) Application of prescribing standards
(c) Ongoing interventions for physicians and pharmacists targeting therapy problems or individuals identified in the course of retrospective DUR. Interventions include inappropriate instances:

1. Information dissemination
2. Written, oral, and electronic reminder
3. Face to face discussions
4. Intensified monitoring/review of providers/dispensers

(6) The DUR Program shall be designed to educate physicians and pharmacists to reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients associated with specific drugs, as well as potential and actual drug reactions, therapeutic appropriateness, over-utilization, under-utilization, appropriate use of generic products, therapeutic duplication, drug/disease contraindications, drug interactions, incorrect drug dosage or duration, drug allergy interactions and clinical abuse/misuse.

(7) The DUR Program will review, analyze and interpret patterns of drug usage against predetermined criteria and standards consistent with the American Medical Association

Drug Evaluations, United States Pharmacopoeia Drug Index, American Hospital Formulary Service Drug Index, and peer reviewed medical literature. The predetermined criteria and standards are available from the Alabama Medicaid Agency or its designated agent.

(8) DUR will be conducted for drugs dispensed to residents of nursing facilities.

Authority: State Plan , Pages 74, 74a, 74b; Title XIX, Social Security Act; 42 CFR Section 440.120; Public Law 101-508. Emergency Rule effective July 1, 1993. Permanent rule effective October 28, 1993. Amended February 11, 1997. Amended November 12, 1997. Effective date of this amendment is February 10, 1998.

Rule No. 560-X-16-.24. Prospective DUR.

(1) Prospective DUR (PRODUR) is required at the point of sale or distribution before each prescription is filled or delivered to a Medicaid recipient. It must include screening, patient counseling, and patient profiles.

(2) Screening - The review must include screening for potential drug therapy problems as specified by the Alabama State Board of Pharmacy. This includes screens for:

(a) Therapeutic duplication means the prescribing and dispensing, where overlapping periods of drug administration are involved and where such prescribing or dispensing is not medically indicated of: (1) two or more doses of the same drug, (2) at least two drugs from the same therapeutic class, or (3) at least two drugs from different therapeutic classes with similar pharmacological effects being used for the same indication.

(b) Drug/Disease contraindications
(c) Drug interactions
(d) Incorrect dosage or duration of drug treatment
(e) Drug allergy interactions, and
(f) Clinical abuse/misuse

(3) PRODUR screening must use predetermined standards which are based upon the peer-reviewed medical literature and the three compendia referenced in Rule No. 560-X-16-.23(7). Criteria and standards developed by the DUR Board will be distributed to the providers by Medicaid in Medicaid Provider Notices and/or Bulletins.

(4) PRODUR screening is the sole responsibility of each Medicaid participating pharmacy and is a requirement for participation in the program.

(5) Prospective DUR screening will be conducted through the Medicaid electronic claims processing system. Pharmacists must respond to prospective DUR alerts to continue claims processing through the Medicaid fiscal agent.

(6) Pharmacies without computers must screen based on guidelines provided by the Alabama State Board of Pharmacy Practice Act and criteria and standards endorsed by the DUR Board.

(7) In the absence of patient-specific diagnosis or allergy information, the pharmacist should consult the patient or the patient's health care provider, if in the pharmacist's judgment, obtaining such information is essential.

(8) Patient counseling shall be offered to all Medicaid recipients receiving new prescriptions and, where appropriate, refill prescriptions and such counseling will be in conformance with guidelines as established by the Alabama State Board of Pharmacy. This regulation includes prescriptions dispensed by mail-order pharmacies. The act specifies that it is permissible for the offer to counsel to be made in a written communication, by telephone, or in a manner determined by the pharmacist to be appropriate.

(9) Patient profiles shall be maintained on all Medicaid recipients receiving medications. The pharmacist must make a reasonable effort to obtain, record, and maintain information as outlined in the Alabama State Board of Pharmacy Practice Act. At a minimum, profiles should contain.

(a) Patient name, age, gender, address and phone number;

(b) Individual patient history, including a list of prescription medications and devices, where appropriate; and

(c) Pharmacist comments.

(10) Each pharmacy provider shall maintain a recipient log that indicates whether or not counseling was offered, and provided.

Authority: State Plan, Page 74a; Title XIX, Social Security Act; 42 CFR Section 440.120; Public Law 101-508. Emergency rule effective July 1, 1993. Permanent rule effective October 28, 1993. Effective date of this amendment is February 11, 1997.

Rule No. 560-X-16-.25. Retrospective DUR.

(1) The retrospective DUR Program reviews, analyzes and interprets patterns of recipient drug usage by applying criteria and standards, developed by the DUR Board, against claims data through periodic examination to identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care. Cases of possible fraud and/or abuse shall be referred to the Medicaid Program Integrity Division.

Authority: State Plan, Page 74a; Title XIX, Social Security Act; 42 CFR Section 440.120; Public Law 101-508. Emergency rule effective July 1, 1993. Permanent rule effective October 28, 1993.

Rule No. 560-X-16-.26. Educational Program.

(1) The purpose of this program is to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

(2) Drug use criteria and standards, established by the DUR Board shall be applied to the drug database after the medication is dispensed. In instances where pharmaceutical use deviates from the criteria and standards, the profile shall undergo further review and possible intervention if appropriate.

(3) Educational program intervention include:

(a) Dissemination of information to physicians and pharmacists in the State concerning the duties and powers of the DUR Board and the basis for the standards used in assessing drug use.

(b) Written, oral, or electronic reminders containing patient-specific or drug-specific information (or both) and suggested changes in prescribing or dispensing practices.

(c) Face-to-face discussions, with follow up discussions when necessary, between health care professionals expert in appropriate drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention on optimal prescribing, dispensing, or pharmacy care practices.

(d) Intensified review or monitoring of selected prescribers or dispensers.

Authority: State Plan, Page 74b; Title XIX, Social Security Act; 42 CFR Section 440.120; Public Law 101-508. Emergency rule effective July 1, 1993. Permanent rule effective October 28, 1993.

Rule No. 560-X-16-.27 Preferred Drug List

(1) The Alabama Medicaid Agency will utilize a preferred drug list for determination of drugs available for reimbursement under the Medicaid Program without prior authorization. For reimbursement under the Medicaid Program, use of the Preferred Drug list is mandatory. Drugs not included on the list may be available through the prior authorization process. Medicaid shall strive to ensure any restriction on pharmaceutical use does not increase overall health care costs to Medicaid.

(2) Over the counter drugs covered by Medicaid will be considered preferred drugs for purposes of this rule. Over the counter drugs will not appear on the preferred drug list.

(3) The Alabama Medicaid Agency will utilize the Pharmacy and Therapeutics Committee to review and recommend drugs for the Preferred Drug List. The Committee will consist of three clinical pharmacists licensed to practice in the state of Alabama including at least one independent pharmacist and one long term care pharmacist, and at least five physicians licensed to practice medicine in the state of Alabama. Physician members will be appointed by the Medicaid Commissioner from a list of at least two nominees for each position submitted by Medical Association of the State of Alabama. Clinical pharmacist members will be nominated by the Alabama Pharmacy Association and appointed by the Medicaid Commissioner; pursuant to state law governing professional services. Members will serve staggered two year terms and may be reappointed to the Pharmacy and Therapeutics Committee for additional terms.

(4) Drugs will be considered for the preferred drug list based on the following:

(a) clinical efficacy
(b) side effect profiles
(c) appropriate usage
(d) cost

(5) Meetings of the Pharmacy and Therapeutics Committee shall meet the requirements of the State open meetings law, and documents relating to a recommendation by the Committee shall be available under the State's public records law.

(6) Pharmaceutical manufacturers may request a product review by the Medicaid Pharmacy and Therapeutics Committee of any new pharmaceutical product falling within the scope of the Medicaid preferred drug list. The request must be in writing and directed to the Pharmacy Program Director. Reviews will be placed on the agenda for review in the order in which they are received.

(7) Medicaid will maintain a database of industry representatives for correspondence and notice regarding the Preferred Drug Program. Manufacturers are responsible for providing accurate contact information to Medicaid. Medicaid will update the information bi-annually. If no contact information is provided, Medicaid will utilize contact information on file with the Medicaid Drug Rebate Program.

(8) Medicaid will send written notice not less than thirty (30) calendar days prior to a meeting of the Pharmacy and Therapeutics Committee to manufacturers whose brand name drug(s) will be considered for preferred status at the meeting.

(9) A product or a product with a new indication must have been on the market for a minimum of six (6) months before a review can be requested. Requests must be in writing and clearly labeled as a request for product review. Evidence supporting inclusion of the product may be submitted in writing and clearly labeled as part of the request for product review.

(10) Pharmaceutical manufacturers may submit evidence supportive of inclusion of a product on the Medicaid Preferred Drug List to be reviewed by the Pharmacy and Therapeutics Committee. Written comments must meet the following requirements:

(a) Must be received by Medicaid at least twenty-one (21) calendar days prior to the Pharmacy and Therapeutics Committee meeting. Deadlines falling on weekends or holidays must be received by noon CST of the next business day.

(b) Must be clinically based.

(c) Must not contain cost information. Submissions with cost information will be rejected in its entirety.

(d) Must be clearly labeled and indicate the class of products represented.

(e) Must provide to Medicaid twenty (20) copies by the deadline.

(11) Pharmaceutical manufacturers may make oral presentations to the Pharmacy and Therapeutics Committee on products being reviewed for preferred status. Oral presentations must meet the following requirements:

(a) Limited to five (5) minutes per drug class.

(b) Limited to one (1) representative and one (1) presentation per product.

(c) Limited to branded products within the class being considered.

(d) No cost information can be addressed. Inclusion of cost information will terminate the presentation.

(e) Must submit a one (1) page summary of the presentation twenty-one (21) calendar days prior to the meeting. See 10(a) above.

(f) Must provide twenty (20) copies if summary is to be distributed to Committee members at meeting. Copies must be submitted to Medicaid at sign-in.

(g) Presenters must sign-in at the registration table a minimum of ten (10) minutes prior to the scheduled start time of meeting. Failure to sign-in will result in elimination of the oral presentation.

(h) No visual aids other than designated handouts are allowed.

(12) Manufacturers may request a reconsideration of a clinical recommendation of the Pharmacy and Therapeutics Committee. Written requests should be submitted to the Medicaid Pharmacy Director and received no later than thirty (30) calendar days following the posting of the final Preferred Drug List to the Medicaid website. Requests must include clinical documentation including references to justify a reconsideration. Manufacturer contact information should be included with the submission. Medicaid will respond to requests for reconsideration within ninety (90) calendar days of receipt.

Author: Louise Jones, Director, Pharmacy Services.
Statutory Authority: State Plan Attachment 3.1-A and 4.18-B; Title XIX, Social Security Act; 42 CFR Section 447.331 & Section 401, et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).
History: New Rule Filed June 21, 2004; Effective September 17, 2004.

Rule No. 560-X-16-.28 – Prior Authorization

(1) The use and payment of drug items may be restricted and require prior authorization. The Alabama Medicaid Agency will utilize the Pharmacy and Therapeutics Committee to review and recommend drugs for prior authorization.

(2) Drug class is defined as a therapeutic group of pharmaceutical agents approved by the FDA as defined by the American Hospital Formulary Service. Medicaid or the Pharmacy and Therapeutics Committee may recommend a review to determine if prior authorization is appropriate for a single drug or a drug class. The Pharmacy and Therapeutics Committee will conduct such reviews, submit clinical data to Medicaid and make a recommendation. The Medicaid Commissioner will make the determination for placement on prior authorization.

(3) The requirement for prior authorization of a drug will be based on a clinical review by the Pharmacy and Therapeutics Committee of all relevant clinical and medical considerations including, but not limited to, Medicaid Drug Utilization Review (DUR) data, Surveillance Utilization Review (SUR) data, potential abuse, misuse, or inappropriate prescribing and/or dispensing patterns by Alabama providers, inconsistency with FDA approved labeling, inconsistency with uses recognized in the American Hospital Formulary Service Drug Information, the authoritative source on sound clinical evidence found in labeling, drug compendia, and peer reviewed clinical literature on use of the drug.

(4) Clinical bases for recommendations of the Pharmacy and Therapeutics Committee will be in writing and available upon written request. Recommendations contrary to prevailing clinical evidence will be justified in writing and available upon written request. Medicaid will prepare a synopsis of the clinical reasoning supporting recommendations which will be available upon written request.

(5) Medicaid may require prior authorization for generic drugs only in instances when the cost of the generic product is significantly greater than the net cost of the brand product in the same American Hospital Formulary Services (AHFS) therapeutic class or when there is a clinical concern regarding safety, overuse or abuse of the product. Medicaid must document the reason for prior authorization of any generic product to include the cost effectiveness of such action or clinical concern.

(6) Medicaid will develop a set of medical criteria specifying the requirements for coverage authorization. The criteria will be available to the public.

(7) Requests for prior authorization must be initiated by the practitioner when deemed medically necessary.

(8) Prior authorizations will be reviewed by Medicaid or its designated agent. When medical criteria as determined by Medicaid are met, the prior authorization will be granted. If denied, adequate medical justification may be submitted in writing by the prescribing physician for reconsideration.

(9) Responses to requests for prior authorization should be issued within eight (8) hours but in no case more than twenty-four (24) hours after receipt of the request. In cases of emergency, provisions are made for dispensing a seventy-two (72) hour supply of a covered outpatient prescription drug.

(10) Effective March 18, 2011, the Alabama Medicaid Agency will implement a Gold Standard Program, an incentive program for high PDL compliant prescribing providers that will reward a limited group of providers with prior authorization (PA) exemption of drugs when certain prescription-based criteria are met in a given timeframe on a regular basis. Certain exclusions will apply. Alabama Medicaid will determine which providers meet and maintain the Gold Standard program criteria on a regular basis.

Author: Tiffany Minnifield, Associate Director, Pharmacy Administrative Services.
Statutory Authority: State Plan Attachment 3.1-A and 4.19-B; Title XIX, Social Security Act; 42 CFR Section 447.331 & Section 401, et seq.; Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508).
History: New Rule Filed June 21, 2004; Effective September 17, 2004. **Amended:** Filed April 20, 2005; effective July 15, 2005. **Amended:** Filed December 20, 2010; effective March 18, 2011.

Rule No. 560-X-16-.29. Annual Report.

(1) The DUR Board must submit an annual report to the Medicaid Agency containing information specified by the state. The Agency must submit, annually, a report to the secretary of Health and Human Services through the HCFA Regional Office that incorporates the DUR Board Report. It must include:

(a) A description of the nature and scope of the prospective drug review program.

(b) A description of how pharmacies performing prospective DUR without computers are expected to comply with the statutory requirement for written criteria.

(c) Detailed information on the specific criteria and standards in use.

(d) A description of the steps taken by the State to include in the prospective and retrospective DUR program drugs dispensed to residents of a nursing facility that is not in compliance with approved drug regimen review procedures.

(e) A description of the actions taken by the State Medicaid agency and the DUR Board to ensure compliance with he requirements for predetermined standards and with the access to the predetermined standards requirement.

(f) A description of the nature and scope of the retrospective DUR program.

(g) A summary of the educational interventions used and an assessment of the effective of these educational interventions on the quality of care.

(h) A description of the steps taken by the State Agency to monitor compliance by pharmacies with the prospective DUR counseling requirements contained in Federal and State laws and regulations.

(i) Clear statements of purpose that delineate the respective goals, objectives, and scopes of responsibility of the DUR and surveillance and utilization review (SUR) functions.

(j) An estimate of the cost savings generated as a result of the DUR program. This report must identify costs of DUR and savings to the Medicaid drug program attributable to prospective and retrospective DUR.

Authority: State Plan, Title XIX, Page 74b; Social Security Act; 42 CFR Section 440.120; Public Law 101-508. Emergency rule effective July 1, 1993. Permanent rule effective October 28, 1993. The effective date of this amendment is February 11, 1997.

Rule No. 560-X-16-.30 Hospice Services

(1) Reimbursement for disease specific drugs related to the recipient's terminal illness and drugs related to the terminal illness found on the Hospice Palliative Drug List (HPDL) are included in the per diem for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website at www.medicaid.alabama.gov.

Author: Kelli Littlejohn, RPh, Director, Pharmacy Services
Statutory Authority: Title XIX, Social Security; 42 CFR Section 418.302; State Medicaid Manual; and State Plan.
History: New Rule: Filed April, 20, 2007; effective August 1, 2007.

Rule No. 560-X-16-.31. Hemophilia Management Standards of Care.

In order to be paid for providing blood clotting factor to Alabama Medicaid recipients, the provider must agree to provide, at the minimum, the following clinically appropriate items and services to their patients with hemophilia and blood clotting factor-related diseases:

(1) Home or office delivery of blood clotting factor and supplies. All shipments/delivery of clotting factor, including overnight deliveries, must use appropriate cold chain management and packaging practices to ensure proper temperature, drug stability, integrity, and efficacy are maintained during shipment.

(2) Educational materials and programs.

(a) The provider shall develop a training library at each enrolled provider location with materials for patient use, to include but not limited to, audio, video, electronic, and written materials.

(b) The provider shall offer educational materials to patient or family/caregiver at minimum at initiation of participation with the provider, yearly during the in-home assessment, and upon the request of Medicaid, the prescribing physician, or patient or family/caregiver.

(c) Topics of education shall include, but not be limited to, specific patient and family/caregiver education aimed at preventing injury that would result in a bleed, self-administration and reconstitution of blood clotting products.

(3) Medically necessary ancillary supplies required to perform the actual IV administration of clotting factor. Supplies may be billed to Medicaid through the Durable Medical Equipment (DME) program. In addition, sharps containers and any other necessary biohazardous waste containers shall be provided, as well as pickup and disposal of waste containers according to national, state and local biohazardous waste ordinances.

(4) Emergency telephone support 24 hours a day, 7 days a week to ensure patients are directed appropriately for care in emergent situations.

(5) For the purposes of this Rule and the Alabama Medicaid Agency hemophilia management standards of care, “clinical staff trained in hemophilia and related blood clotting factor related diseases” is defined as follows:

(a) Pharmacists are required to obtain a minimum of 2 Continuing Education (CE) credit hours per year that are specific to hemophilia or related blood clotting factor-related diseases.

(b) Nurses and social workers are required to obtain a minimum of 4 Continuing Education (CEU) hours per year (8 hours every 2 years) that are specific to hemophilia or related blood clotting factor-related diseases.

Continuing education must be specific to hemophilia or related blood clotting factor-related diseases and recognized by a state or national hemophilia or bleeding disorder education/support group (for example: Hemophilia Federation of America or the National Hemophilia Association).

(6) Emergency delivery of blood clotting factor within 24 (with a target of less than 12) hours of the receipt of a prescription for a covered person’s emergent situation, or notification of the patient with an existing valid prescription. Emphasis should be placed during patient education of the importance of keeping an adequate supply on hand and self-administration for emergent situations.

(7) A pharmacist, nurse, and/or a case representative assigned to each patient. A case representative shall maintain, at a minimum, monthly telephone contact with the patient or family/caregiver to include, but not limited to:

-Inquiry regarding patient’s current state of well-being
-Assessment of patient/family compliance/adherence, and persistence with the medical treatment plan
-Incidence of adverse events
-Incidences of supply or equipment malfunctions
-Home inventory check of factor and supplies
-Confirmation of next delivery date

Case representatives may include administrative support staff, but must coordinate with clinical staff (as described in (5) above) in the event a clinical issue should arise.

(8) Compliance programs.

(a) The provider must assess patient adherence on monthly telephone contact (see (7) above) and on all in-home visits by a pharmacist, nurse, or case manager.

(b) The provider must verify the amount of clotting factor the patient has on hand prior to each dispense. Blood clotting factor and related products are not to be sent to the patient on an auto-ship basis. The provider shall discourage "stockpiling" of product.

(c) The number of bleeds and infusions from the prior shipment shall be tracked to validate the need for additional product or non-compliance with the medical treatment plan.

(9) Notification of product recalls or withdrawals.

(a) Any stock of recalled medications/equipment/supplies shall be removed from stock and quarantined immediately.

(b) Any recalled items dispensed to patients shall be retrieved and quarantined; notification to patients must occur within 24 hours of the recall receipt.

(c) The prescribing physician shall be notified of a medication recall. A prescription for an alternative product shall be obtained, if necessary.

(10) Visiting clinical services.

(a) At minimum, an initial and subsequent yearly in-home assessment of the patient, family/caregiver, and environment shall be conducted by a nurse or pharmacist trained in blood clotting factor related diseases.

(b) Additional in-home assessments of the patient, family/caregiver, and environment deemed necessary by the physician or patient situation shall be conducted.

(c) Visits may be provided directly by the provider or by arrangement with a qualified local home health care agency. All hemophilia-related clinical staff must be trained in hemophilia and bleeding disorder related diseases.

(11) A registered pharmacist trained in blood clotting factor related diseases to perform assay to prescription management. Variance in assay to prescription/target dose should not exceed +/- 10%.

(12) Adverse drug reaction and drug interaction monitoring and reporting.

(a) Pharmacists shall counsel the patient or family/caregiver in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) to encourage appropriate medication use, promote realistic therapy expectations, help recipients manage or minimize expected adverse effects and encourage compliance.

(b) Pharmacists shall report any issues or concerns related to the patient's medications to the physician. For significant events, utilization of the FDA 3500 MedWatch voluntary reporting form is encouraged.

(13) Continuation of Care. The provider shall not present any bill to or collect any monies from a covered Medicaid recipient with whom the provider has agreed to the provision of services and supplies for the home treatment of bleeding episodes associated with hemophilia, except as follows:

(a) to collect the copayments/coinsurance amounts the covered person is required to pay under the terms defined by Medicaid, or

(b) if the service/product has been deemed "non-covered" and the recipient has been notified in advance as outlined in the Alabama Medicaid Agency Administrative Code and Provider Billing Manual.

Upon discontinuation of services by the provider, the provider shall, at a minimum, coordinate for another designated health care provider to provide services to covered persons, prior to withdrawal of any hemophilia-related services from the home of any covered person.

The provider shall continue to provide services and supplies to a covered individual until the individual obtains an alternate source of services and supplies. Every effort shall be made by the provider (including notification to the Medicaid Director of Pharmacy) to find an alternative provider to ensure that the coordination of care/transition follows the minimum standards of care as set forth in this document.

(14) The Alabama Medicaid Agency (or its designated representative), to ensure clinically appropriate services are being given to hemophilia patients, shall monitor providers of blood clotting factor by prospective and retrospective audits, as well as administer a patient/family/caregiver satisfaction survey to include, but not limited to, measurement of:

(a) staff availability
(b) staff knowledge
(c) timeliness of deliveries
(d) accuracy of supplies and equipment
(e) overall satisfaction

If a provider does not meet one or more of the standards for care, as outlined in this Rule, the Alabama Medicaid Agency shall provide a written notice of that determination, with an explanation therefore, to the provider. The provider will not be reimbursed for blood clotting factor or hemophilia related services until the provider meets the standards as approved by the Agency.

Author: Kelli D. Littlejohn, RPh, Pharm D, Director, Pharmacy Services
Statutory Authority: State Plan, Attachment 3.1-A and Attachment 4.19-B; Title XIX, Social Security Act; 42 CFR Section 430.0, et seq.
History: New Rule: Filed September 20, 2007; effective December 14, 2007.

Chapter 17. Eye Care Services

Rule No. 560-X-17-.01. Eye Care Services – General.

The information contained herein sets forth policies and procedures for providing eye care services under the Alabama Medicaid Program.

1. Participation. Only in-state and borderline out-of-state providers (within a 30-mile radius of the state line) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. The following information must be included in a written enrollment request to Medicaid's Fiscal Agent, Provider Enrollment Division:
   - (a) Name
   - (b) Address
   - (c) Specialty Provider Type
   - (d) Social Security Number
   - (e) Tax Identification Number
   - (f) Medical License Number
2. Patient Identification
   - (a) It is most important that a provider's staff verify a Medicaid recipient's eligibility, since claims submitted on ineligible persons cannot be paid by Medicaid. Refer to Chapter 1, General, of this Code, for information about identification of Medicaid recipients.
3. Prior Authorization
   - (a) Special exceptions for optometric items, not authorized in this regulation may be made in unusual circumstances when deemed medically necessary by the attending practitioner.
   - (b) All requests for prior authorization will be submitted in writing to Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36103-5624, and must include the following information:
     1. Recipient's name.
     2. Recipient's Medicaid Number (thirteen (13) digits).
     3. Prescription data (complete for both eyes) current.
     4. Exception requested.
     5. Reason for exception (explain) (Cataract surgery date, etc.).
     6. Signature of Practitioner.
     7. Address of Practitioner.
   - (c) A prior authorization number will be assigned by Alabama Medicaid Agency.
   - (d) The number will be reflected on an approval letter for use in completing the appropriate billing form to the fiscal agent.
   - (e) A copy of the approval letter from Alabama Medicaid Agency bearing the prior authorization number must be provided to the central Medicaid source if eyeglasses are being obtained from the central source.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq. Rule effective October 1, 1982. Amended May 9, 1984. Effective date of amendment January 13, 1988. Effective date of amendment January 13, 1993. Effective date of this Amendment is March 13, 1993.

Rule No. 560-X-17-.02. Physician Services for Diseases, Injuries, or Congenital Defects.

1. If medically necessary, treatment may include contact lenses (for keratoconus, aphakia, high magnification difference between lenses), when requested in writing and prior authorized by Alabama Medicaid Agency.
2. Orthoptics (eye exercises) must be prior authorized by Alabama Medicaid Agency. Full information justifying medical necessity (including number of sessions anticipated) must be sent in writing to Medicaid before this service is begun.
3. Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied under this paragraph when needed because of visual changes due to eye disease, surgery, or injury.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq. Rule effective October 1, 1982. Effective date of this amendment is March 13, 1993.

Rule No. 560-X-17-.03. Optometrist Services.

1. Services That May be Provided Other Than Correction of Refractive Error.
   - (a) In the conduct of an optometric eye examination, if the Optometrist suspects or detects abnormalities or irregularities requiring medical treatment the case will be referred to an appropriate doctor of medicine or osteopathy.
   - (b) If medically necessary, contact lenses (for Keratoconus, aphakia, high magnification difference between lenses), may be provided when prior authorized by Medicaid.
   - (c) Orthoptics (eye exercises) must be prior authorized by Alabama Medicaid Agency. Full information justifying medical necessity (including number of sessions anticipated) must be sent in writing to Medicaid before this service is begun.
   - (d) Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied under this paragraph when needed because of visual changes due to eye disease, surgery, or injury.
   - (e) Photochromic lenses and UV400 coating may be prior authorized when justified in writing.
   - (f) Post-operative cataract patients may be referred, with the patient's consent, to an optometrist for follow-up care as permitted by state law. Any subsequent abnormal or unusual conditions diagnosed during follow-up care shall be referred back to the ophthalmologist. When submitting claims the appropriate modifier identifying post-operative management must be utilized. Anytime the surgeon receives payment for the global amount the post-op claim will deny. No post-operative management claim will be processed until referring ophthalomolgist has received payment for surgery. It shall be the responsibility of the optometrist to confer with the surgeon for appropriate claim corrections and/or submissions.
2. Examination for Refractive Error Only.
   - (a) A complete eye examination and work-up is expected and will include the following: case history, eye health examination, visual acuity testing, visual fields (if indicated), tonometry, prescribing eyeglasses (if indicated), and determining optical characteristics of lenses (refraction).
   - (b) For children, eye tension and visual fields should be done only if indicated.
   - (c) Medicaid recipients twenty-one (21) years of age and older are authorized one (1) complete eye examination and work-up each two (2) calendar years; recipients under twenty-one (21) years of age are authorized the same service each calendar year or more often if medically necessary (documented).

(d) Diagnosis will be indicated as refractive error findings.

(e) Services rendered to Medicaid recipients while confined to bed in a health care facility may be rendered as long as it is documented by the patient's assigned physician that the patient is unable to leave the facility and the examination is medically necessary.

3. If eyeglasses are required and provided, services will include verification of prescription, dispensing of eyeglasses (including laboratory selection), frame selection, procurement of eyeglasses, and fitting and adjusting of eyeglasses to the patient.

Authority: Title XIX, Social Security Act; 42 C.F.R., Section 435.520(3), 441.30(a)(b); State Plan, Attachment 3.1-A, page 2.2, and page 5.1. Rule effective October 1, 1982. Amended June 8, 1985. Effective date of emergency rule is December 1, 1986. Amended March 12, 1987. Emergency Rule Effective Date April 15, 1993. Amended May 13, 1993. Effective date of this amendment August 12, 1994.

Rule No. 560-X-17-.04. Eyeglasses.

1. Authorization

(a) Recipients twenty-one (21) years of age and older are authorized one (1) pair of eyeglasses each two (2) calendar years if indicated by an examination; recipients under twenty-one (21) years of age are authorized the same service each calendar year or more often if medically necessary (documented). These limitations also apply to fittings and adjustments.

(b) Additional eyeglasses, which are medically necessary, may be prior authorized by Alabama Medicaid Agency (Medicaid) for treatment of eye injury, disease or significant prescription change.

(c) The provider should forward a letter to Medicaid justifying medical necessity prior to ordering the eyeglasses (reference Rule No. 560-X-17-.01,(3).

(d) A response of either approval or denial will be returned to the provider. If approved, a six digit prior authorization number will be assigned (reference Rule No. 560-X-17-.01, (3), (c) and (d).

(e) If a patient desires eyeglasses other than those provided by Medicaid he/she must pay the complete cost of the eyeglasses, including fitting and adjusting; Medicaid will not pay any part of the charge. To prevent possible later misunderstanding, the provider should have the patient sign the following statement for retention with the patient's records: "I hereby certify that I have been offered Medicaid eyeglasses but prefer to purchase the eyeglasses myself."

2. Procurement.

At the option of the provider making the frame measurements, eyeglasses in conformance with Alabama Medicaid standards, may be procured from either the central Medicaid source or from any other source. Medicaid will pay no more than the contract price charged by the central source.

3. Standards and Price of Frames.

(a) A list of authorized frames and contract prices will be sent to each provider by Alabama Medicaid Agency.

(b) The authorized frames, or frames of equal quality, will be provided for Medicaid recipients at the contract prices shown on the list. (Under normal circumstances the date of service for eyeglasses will be the same as the date of examination.)

(c) Patients having old frames, which are suitable and acceptable under the standards contained herein, may have new lenses installed in lieu of being issued new eyeglasses. Medicaid will pay for the lenses only. The following statement should appear on the claim form that is submitted for the lenses: "I hereby certify that I used this patient's old frames and that I did not accept any remuneration therefore."

(d) Services provided under this sub-paragraph are subject to the program benefit limitations.

4. Lenses.
   (a) Lens specifications are authorized at the specified contract price.
   (b) Lenses will be of clear glass or clear plastic, unless prior authorized by Alabama Medicaid Agency because of unusual conditions, as indicated in Rule 560-X-17-.03(11). All lenses will meet FDS impact-resistant regulations.
   (c) Spherical lenses must be at least a plus or minus.50 diopters; the minimum initial correction for astigmatism only (no other error) is .50 diopters.
   (d) Prior authorization is to be obtained by writing Alabama Medicaid Agency.
5. Frames.
   (a) Patients with old lenses which are suitable and acceptable under the standards contained herein, may have them installed in a new frame in lieu of being issued new eyeglasses. Medicaid will pay for the frame only. The following statement should appear on the claim form that is submitted for the frame: "I hereby certify that I used this patient's old lenses and that I did not accept any remuneration therefore."
   (b) Services provided under this sub-paragraph are subject to the program benefit limitations.

Authority: Title XIX, Social Security Act; 42 C.F.R., Section 435.520(3), Section 441.30(a)(b); State Plan, Attachment 3.1-A, page 2.2 and 5.1. Rule effective October 1, 1982. Amended June 8, 1985. Effective date of emergency rule is December 1, 1986. Amended March 12, 1987. Effective date of this amendment January 13, 1988. Effective date of this amendment is March 13, 1993.

Rule No. 560-X-17-.05. Billing Procedures.

1. All claims for payment of services rendered, filed by Ophthalmologists, Optometrists, and Opticians are to be filed on appropriate form provided by the fiscal agent.
2. Claims are to be forwarded directly to the Medicaid fiscal agent for payment within one year of the date of service. The Medicaid Provider Manual contains information on claims processing.
3. A claim for payment may be submitted for a cancelled order.
4. Eye Examination Only.
   (a) The claim should specify "Complete Eye Examinations and Refraction."
   (b) If services other than a "complete examination" are provided, the claim should reflect the appropriate optometric procedure code. This claim should be sent directly to the Medicaid fiscal agent.
5. Medical Condition and Treatment.
6. The claim should be sent directly to the Medicaid fiscal agent.
7. Eye Examination (Including Refraction) and Fitting (Including Frame Service, Verification, and Subsequent Service) all by the same provider when eyeglasses are procured from the central Medicaid source contractor:
   (a) Claims are to be sent directly to the Medicaid fiscal agent.
   (b) The claim will separately identify the extent of the examination, refraction and fitting. Lenses and frames are not to be billed by the practitioner.
   (c) The Medicaid job order form reflecting all necessary prescription data including frame required will be forwarded to Central Medicaid Source Contractor to fill the prescription, and return the eyeglasses to the examiner for delivery to the patient. Patient or Authorized Signature box will contain appropriate signature, or the statement "Signature on file."

(d) The Central Medicaid Source Contractor will submit claims for payment to the fiscal agent.

7. When eyeglasses are NOT procured from the Central Medicaid Source Contractor.
   (a) The claim should separately specify the extent of the examination performed refraction, fitting, lenses, and frame.
   (b) When Opticians provide eyeglasses the claim should only identify the fitting service, lenses and frame.
   (c) The claim is sent directly to the fiscal agent. Reimbursement for lenses and frames will be at the central source contract prices.
8. Fitting (Including Frame Service, Verification, and Subsequent Service) only, when eyeglasses are procured from the Central Medicaid Source Contractor:
   (a) The claims are to be sent for payment directly to the Medicaid fiscal agent.
   (b) The claim will specify the fitting services only.
9. Additional billing instructions will be published as the need arises by the Medicaid fiscal agent.
10. An Alabama Medicaid provider may bill an Alabama Medicaid recipient when the recipient has exhausted all of his/her allowed Medicaid benefits for the calendar year, or when the service rendered by the provider is a non-covered benefit as outlined in the Alabama Medicaid Agency Administrative Code.
    (a) Conditional collections to be refunded post payment by Medicaid and partial charges for balance of Medicaid allowed reimbursement are prohibited.
11. Ophthalmologists and optometrists are required to collect and it is the Medicaid recipient's responsibility to pay the maximum designated copayment amount for each service rendered. This includes patients with Medicare.
    (a) A provider agrees to accept as payment in full the amount paid by the State, plus any cost-sharing amount to be paid by the recipient, for covered items, and further agrees to make no additional charge(s) for covered items to the recipient, sponsor, or family of the recipient, except the appropriate allowable copayment amount.

Authority: State Plan, Attachment 4.18-A; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq.; Section 447.15. Rule effective October 1, 1982. Amended July 9, 1984. Effective date of amendment June 8, 1985. Effective date of this Amendment is March 13, 1993.

Rule No. 560-X-17-.06. Professional Fees.

All eye care service providers shall be paid their usual and customary fees in accordance with Federal regulations for all services rendered, including examinations and the prescribing, procuring, and fitting and adjusting of eyeglasses, not to exceed the 75th percentile of the range of fees prevailing in the statewide profile.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, Et seq. Rule effective October 1, 1982.

Rule No. 560-X-17-.07. Special Situations.

1. Eye Care for Patients Eligible for Both Medicare and Medicaid.
2. See the Medicaid Provider Manual for instructions in filing claims when the Medicaid patient is entitled to benefits covered by Medicare.
3. If eyeglasses are prescribed under conditions not covered by Medicare, instructions and procedures appearing in other paragraphs of this chapter should be followed.
4. Unusual Situations.
   - (a) Services for unusual situations may be provided when prior authorized. Full, written information justifying medical necessity must be sent to Medicaid prior to the service being rendered.
   - (b) Please refer to Rule No. 560-X-17-.01, (3) of this chapter for prior authorization procedures.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 401, Et seq. Rule effective October 1, 1982. Effective date of this amendment January 13, 1988.

Rule No. 560-X-17-.08. Assuring High Quality Care.

Under the provisions of Federal and State law, Medicaid must establish a mechanism to insure that all such care is of good quality and that the service(s) for which billing was made, conforms to that which was done. See Chapter 2, Rule 560-X-2-.01 (2) (f) and (3), for criteria.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 401, Et seq. Rule effective October 1, 1982.

Rule No. 560-X-17.-09. Copayment (Cost-Sharing).

1. Ophthalmologists and optometrists are required to collect and it is the Medicaid recipient's responsibility to pay the maximum designated copayment amount for each service rendered.
2. The copayment amount does not apply to services provided for the following:
   - (a) Recipients under 18 years of age
   - (b) Emergencies
   - (c) Pregnancy
   - (d) Nursing home residents
3. A provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount.

Authority: State Plan, Attachment 4.18-A; 42 C.F.R. Section 447.15, 447.50, 447.55. Rule effective June 8, 1985.

Chapter 18. Transportation Services.

Rule No. 560-X-18-.01. Transportation Services - General.

(1) The Title XIX (Medicaid) Plan for Alabama provides for transportation of eligible recipients to and from sources of medical care. Service will be provided either as a benefit or as an administrative expense through methods ranging from voluntary no-cost to paid ambulance transportation.

(2) The approved plan includes:

(a) Reimbursement of ambulance service for emergency and nonemergency situations without prior approval and special situations with preauthorization given by Alabama Medicaid Agency; and

(b) Coordination with the Department of Human Resources to conduct a program within the counties to arrange for transportation from existing recognized nonprofit volunteer groups.

Authority: State Plan, 42 C.F.R. Section 401, et seq.; and Title XIX, Social Security Act. Rule effective October 1, 1982. Effective date of this amendment August 12, 1994.

Rule No. 560-X-18-.02. Definitions.

(1) Recipient

An individual determined to be eligible for Medicaid under the state plan.

(2) Ambulance

(a) Vehicle specifically designed and equipped for transporting the wounded, injured, ill, or sick. Medicaid recognizes three levels of ambulance services: Basic Life Support (BLS), Advanced Life Support (ALS), and Non-emergency Ambulance Transportation. For a concise definition of these ambulance services refer to the Ambulance (Ground & Air) and/or Non-emergency Transportation (NET) Program chapters of the Alabama Medicaid Provider Manual.

(b) All ambulances licensed and operating in Alabama shall have the essential equipment on board as listed in Rule No. 420-2-1-.04, Ambulance Vehicle Specifications; Emergency Medical Services Rules; Alabama Department of Public Health. Effective date of this publication is January 1991.

(c) Exceptions: The above referred rules, regulations, and standards shall not apply to:

1. Volunteer rescue squads that are members of Alabama Association of Rescue Squads.
2. Ambulances operated by federal agencies.
3. Ambulances which are rendering assistance to licensed ambulances in the case of an emergency in which the licensed ambulances of Alabama are insufficient or unable to provide necessary ambulance services.

4. Ambulances which are operated from a location or headquarters outside Alabama that transport patients from outside the state to locations within the state.

(d) No out-of-state ambulance shall be used to pick up patients for transportation point-to-point within Alabama unless the ambulance operator and ambulance attendant hold current Alabama licenses.

(3) License

No person shall be employed as ambulance attendant, ambulance driver, or ambulance driver-attendant; nor shall any person, firm, or corporation operate an ambulance, or ambulances, on the streets, alleys, or any public way or place in the State of Alabama without having first obtained a valid license from the Emergency Medical Service Division of the Alabama Department of Public Health.

(4) Emergency - Medical conditions of a serious or urgent nature that warrant immediate action to prevent the death or serious impairment of the health of the individual, e.g., accident, heart attack, acute stroke, etc..

(5) Accident - An unexpected happening causing loss or injury to the recipient.

(6) Qualified Provider of Medical Care - The medical source generally available and used by other residents of the community, if that source participates in the Medicaid program.

(7) Evident hardship - May justify an exception from the specific regulation where it is referenced, when the length of the trip, the frequency of the travel or the lack of other practical alternative makes such an exception reasonable.

Author: Ginger Collum, Program Manager, Clinic/Ancillary Services
Statutory Authority: State Plan; 42 C.F.R. Section 401, et seq.; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended January 1, 1996, March 14, 1996, and August 12, 1994. Amended: Filed May 22, 2001; effective August 16, 2001.

Rule No. 560-X-18-.03. Prior Authorization.

(1) All nonemergency ambulance service rendered to eligible Alabama Medicaid recipients 100 miles or more one way where medical care is received, requires prior authorization.

(2) All requests for prior authorization by the attending physicians or their representatives will be directed to Medicaid's Fiscal Agent.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: State Plan, Attachment 3.1-A, Page 9.24 and Attachment 3.1-D, Pages 1 and 2; 42 CFR Section 401, et seq.; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Emergency Rule effective January 1, 1996. Effective date of this amendment March 14, 1996. **Amended:** Filed November 17, 2008; effective February 11, 2009.

Rule No. 560-X-18-.04. Scope of Ambulance Transportation Service Operations.

(1) All transportation must be medically necessary and reasonable. Documentation must state the condition(s) that show necessity of ambulance service, (and indicate why patient could not be transported by another mode of transportation).

(2) No payment may be made for ambulance service if some other means of transportation could be utilized without endangering the recipient's health.

(3) Emergency ambulance services are provided to eligible recipients between:

(a) Scene (address) of emergency and local hospital.

(b) Nursing home and local hospital.

(c) Local hospital and specialized hospital

(Example: From Montgomery to University of Alabama Hospital in Birmingham).

(d) Exception: Ambulance service to a physician's office is not considered an emergency.

(4) Payment may be made if the eligible recipient expires en route to or from a health care facility. Payment may not be made if the recipient was pronounced dead by a legally authorized individual prior to transport.

(5) More than one eligible recipient may be transferred in the same ambulance at the same time. A separate claim form must be filed for each recipient.

(6) Nonemergency ambulance service is provided to eligible recipients who must be bed-confined or have a debilitating physical condition(s) that require travel by stretcher only and require transportation to receive medical services.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: State Plan, Attachment 3.1-A, Page 9.24 and Attachment 3.1-D, Pages 1 and 2; 42 CFR Section 431.53; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. **Amended** June 28, 1991, October 12, 1991, April 14, 1992, August 12, 1994, January 1, 1996, March 14, 1996, and August 16, 2001. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed November 17, 2008; effective February 11, 2009.

Rule No. 560-X-18-.05. Ambulance Service Participation.

(1) All in-state and borderline out-of-state providers (within a 30-mile radius of the state line), in compliance with Rule No. 560-X-18-.02(2)(b) above, will be afforded an opportunity to sign an ambulance service contract with Alabama Medicaid Agency, to participate in the program for providing ambulance service to Title XIX eligible recipients. Written enrollment requests should be forwarded to Transportation Services, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104.

(2) The following items require that a new Ambulance Service contract be entered into with the Alabama Medicaid Agency:

(a) Expiration of State License and new license issued.

(b) Change of ownership.

(3) The fiscal agent will be responsible for enrolling any Title XVIII (Medicare) qualified ambulance service that wishes to enroll in the Medicaid Transportation Program as a QMB-only provider.

Authority: State Plan; Attachment 3.1-A; Title XIX, Social Security Act; 42 C.F.R. Sections 431.53, 441.62. Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360). Rule effective October 1, 1982. Amended May 9, 1984, January 1, 1987, and July 13, 1989. Effective date of this amendment August 12, 1994.

Rule No. 560-X-18-.06. Payment for Services.

(1) The transportation provider is responsible for completion of the HCFA 1500 claim form. All claims submitted will be required to include the diagnosis code, modifiers, and indicators as appropriate.

(2) Payment for ambulance services shall be based on the lesser of the submitted charge or Alabama Medicaid's statewide ambulance service rate. These payments shall not exceed combined payments for providing comparable services under comparable circumstances under Medicare and/or more than the prevailing charges in the locality for comparable services under comparable circumstance.

(3) Air transportation for adults 21 years of age and older will be reimbursed at the emergency ground rate.

(4) Ambulance services billed will be commensurate with services actually performed. Services rendered are independent of the type of call received or the type staff/equipped ambulance service responding.

(5) An Alabama Medicaid Provider may bill an Alabama Medicaid recipient when the recipient has exhausted all of his/her allowed Medicaid benefits for the calendar year, or when

the service rendered by the provider is a non-covered benefit as outlined in the Alabama Medicaid Agency Administrative Code.

Author: Ginger Collum**,** Program Manager, Clinic/Ancillary Services.
Statutory Authority: State Plan; 42 C.F.R. Section 401, et seq.; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended July 9, 1984, January 1, 1987 and August 12, 1994. Amended: Filed March 20, 2002; effective June 14, 2002.

Rule No. 560-X-18-.07. Time Limitation for Filing Medicaid Claims.

Claims for payment (appropriate forms provided by fiscal agent for Medicaid) from provider of service shall be submitted to fiscal agent for Medicaid within one year of the date of service.

Authority: State Plan; 42 C.F.R. Section 401, et seq.; and Title XIX, Social Security Act. Rule effective October 1, 1982.

Rule No. 560-X-18-.08. Third Party Responsibility.

(1) Please refer to Chapter No. 560-X-20, Third Party, for information concerning filing insurance and release of information pertaining to recipients' changes.

Authority: State Plan; 42 C.F.R. Section 401, et seq.; and Title XIX, Social Security Act. Rule effective October 1, 1982. Effective date of this amendment December 6, 1984.

Rule No. 560-X-18-.09. Individuals Eligible for Both Medicare and Medicaid.

(1) An individual who is either sixty-five (65) years of age or older, who is under sixty-five years of age, and who has been receiving green Social Security disability checks for twenty-four (24) consecutive months, who presents a current white Medicaid Eligibility Card without a Medicare Claim Number should be questioned about coverage under Medicare.

(2) If the recipient does not have a Medicare card and if he/she has not applied for Medicare, he/she should be advised to contact the District Social Security Office immediately.

(3) Claims should not be filed with Medicaid until the Social Security Office makes a determination about eligibility for Medicare.

(4) Please refer to Chapter 1, General.

Authority: State Plan: 42 C.F.R. Section 401, et seq.; and Title XIX, Social Security Act. Rule effective October 1, 1982. Effective date of this amendment August 12, 1994.

Rule No. 560-X-18-.10. Volunteer Services

Alabama Medicaid Agency and the Department of Human Resources (county level) shall work for procurement of additional volunteer transportation support from volunteer groups and nonprofit organizations.

Authority: State Plan; 42 C.F.R. Section 401, et seq.; and Title XIX, Social Security Act. Rule effective October 1, 1982. Effective date of this amendment August 12, 1994.

Rule No. 560-X-18-.11. Out-of-State Transportation.

(1) All written or verbal communications pertaining to Alabama Medicaid recipients, from out-of-state physicians or providers of ambulance transportation, will be referred to Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104.

(2) Appropriate billing forms will be provided at a fee to ambulance service providers upon request.

(3) Payment will be as stated in Rule No. 560-X-18-.07.

(4) Processing for payment will be the same as Rule No. 560-X-18-.13(6) and (8).

(5) All out-of-state providers of ambulance service are responsible for compliance with all applicable paragraphs of this Alabama Medicaid Regulations Manual, when requesting payment for service provided an eligible Alabama Medicaid recipient.

Authority: State Plan; 42 C.F.R. Section 401, et seq.; and Title XIX, Social Security Act. Rule effective October 1, 1982. Effective date of this amendment August 12, 1994.

Rule No. 560-X-18-.12. Providers of Service Procedures.

(1) To be eligible for participation in the Alabama Medicaid Ambulance Program and to receive payment for service, each provider of ambulance service in Alabama in compliance with Rule No. 560-X-18-.02(2) must enter into a written agreement with Alabama Medicaid Agency.

(2) Ambulance Service Agreement (contract) available from the Alabama Medicaid Agency, must be completed in two copies.

(3) Contract must be approved by Alabama Medicaid Agency with an effective date for payment of Medicaid covered ambulance services. The effective date of the contract will be the first day of the month the Agency signs the contract.

(4) The Ambulance Service Agreement (contract) may be terminated for failure of the parties to fulfill one or more of the contract provisions. Medicaid reserves the right to immediately terminate a contract in the event of fraud or a criminal conviction.

(5) Each party may terminate the agreement on thirty days written notice.

(6) The permanent record copy which fully disclose the extent and cost of services, equipment, or supplies furnished eligible recipients must be maintained by the provider and available for audit by State and Federal auditors for a period of three years.

(7) Providers of transportation are responsible for verifying the recipient's current Medicaid eligibility.

(8) All required blanks and spaces on the claim form must be completed before submitting it to the Medicaid fiscal agent for payment.

Authority: State Plan; 42 C.F.R. Section 401, et seq.; and Title XIX, Social Security Act. Rule effective October 1, 1982. Amended January 1, 1987, January 13, 1993, and October 14, 1993. Effective date of this amendment August 12, 1994.

Rule No. 560-X-18-.13. Providers of Ambulance Service Responsibilities.

(1) Act No. 645 passed by the 1976 Regular Session of the Legislature of Alabama provided that any person who, with intent to defraud or deceive, makes or causes to be made, any false statement or representation of material fact in any claim or application for any payment, regardless of the amount from Alabama Medicaid Agency, knowing the same to be false, shall be guilty of a felony.

(2) All services will be provided without discrimination of race, color, or national origin, as in accordance with the provisions of Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973.

(3) The provider of Ambulance Services, will assume all responsibility for operation of the service if a medical/legal accident should occur.

Authority: State Plan; 42 C.F.R. Section 401, et seq.; Title XIX, Social Security Act. Rule effective October 1, 1982.

Rule No. 560-X-18-.14. Assuring High Quality Care.

(1) Under the provisions of Federal and State law, Medicaid must establish a mechanism to insure that all such care is of good quality and that the service(s) for which billing was made, conforms to that which was done. See Chapter 2, Rule 560-X-2-.01 (2) and (3) for criteria.

Authority: State Plan; 42 C.F.R. Section 401, et seq.; Title XIX, Social Security Act. Rule effective October 1, 1982.

Rule No. 560-X-18-.15 Air Transportation Services

(1) Covered Services

(a) Air transportation services are covered for adults and children with authorization required prior to payment. Air transportation may be rendered only when basic and advanced life support land ambulance services are not appropriate. Medical appropriateness may be established when the time of need to transport by land or the instability, inaccessibility, or other obstacles to land transportation poses a threat to survival or seriously endangers the recipient's health. In certain cases when time required to transport by land as opposed to air endangers the recipient's life or health, services may be authorized. Air transportation will not be provided for convenience.

(b) Medicaid requires that the patient be taken to the nearest hospital having appropriate facilities, physicians, or physician specialist needed to treat the patient's condition. The hospital must also have a bed or specialized treatment unit immediately available. If the patient is not taken to the nearest appropriate hospital, payment will be limited to the rate for the distance from the pick up point to the nearest appropriate hospital.

(c) If it is determined that land ambulance service would have been more appropriate, payment for air transportation will be based on the amount payable for land transportation. Trips less than 75 loaded air miles are not considered to be appropriate unless extreme, extenuating circumstances are present and documented.

Author: Ginger Collum, Program Manager, Clinic/Ancillary Services
Statutory Authority: State Plan, 42 C.F.R. Section 431.53 and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Emergency Rule effective June 28, 1991. Amended April 14, 1992, April 15, 1993, August 12, 1994, October 13, 1998. Amended: Filed December 17, 2001, effective March 15, 2002. Amended: Filed March 20, 2002; effective June 14, 2002.
Amended: Filed March 22, 2004, effective June 16, 2004.

Rule No. 560-X-18-.16. Non-Emergency Transportation (NET) -General.

(1) As the State Agency for administering the Non-Emergency Transportation Program, under Title XIX of the Social Security Act, the Alabama Medicaid Agency must ensure that transportation for Medicaid covered medical services is available for all eligible recipients in the state who have no other means of transportation.

(2) Medical transportation services include transportation of a Medicaid recipient to and from Medicaid covered medical service for which a recipient has available benefits.

(3) In order to eliminate or reduce transportation barriers for Medicaid recipients, Medicaid created the Non-Emergency Transportation Program (NET). NET is responsible for ensuring that necessary non-ambulance transportation services are provided in a manner that is:

(a) similar in scope and duration state-wide, although there will be some variation depending on resources that are available in a particular geographical location of the state;

(b) consistent with the best interest of recipients;

(c) appropriate to available services, geographic location and limitations of recipients:

(d) prompt, cost effective and efficient

(4) All payments for Non-Emergency Transportation services must have prior authorization by the Alabama Medicaid Agency, with the exception of those services listed in Rule 560-X-18-.04(6), and those services requiring urgent care.

(a) Urgent care is defined as medical care that is required after normal business hours.

(b) Request for reimbursements for Non-Emergency Transportation as a result of urgent care, must be made the first business day after the transportation need has occurred.

Author: Dorothy Powell, Associate Director, Non-Emergency Transportation Program
Authority: State Plan; 42 C.F.R., Section 431.53; and Title XIX, Social Security Act.
Emergency rule effective January 1, 1996. Effective date of this rule March 14, 1996.
Amended: Filed June 21, 2010; Effective September 15, 2010.

Rule No. 560-X-18-.17. NET Trip Eligibility.

(1) Eligible recipients must receive the least expensive appropriate transportation,that does not endanger their health, to facilities that are accessible and appropriate for Medicaid covered medical services for which a recipient has available benefits.

(2) Recipients who request out-of-state transportation to medical facilities must have a physician submit to the Alabama Medicaid Agency a physician's statement which justifies the need for medical services out-of-state and that such services cannot be obtained in-state.

Author: Dorothy Powell, Associate Director, Non-Emergency Transportation Program

Authority: State Plan, 42 C.F.R. Section 431.53 and Title XIX, Social Security Act. Emergency rule effective January 1, 1996. Effective date of this rule March 14, 1996.
Amended: Filed June 21, 2010; Effective September 15, 2010.

Rule No. 560-X-18-.18. Reimbursement for NET.

(1) Reimbursement for transportation services is furnished through an Electronic Benefit Transfer System (EBT) process wherein the recipient uses the reimbursement to purchase transportation. Non-emergency ambulance transportation is reimbursed fee for service.

(2) A tiered fee for transportation payment structure is utilized based upon factors such as: mileage; client's physical, mental or medical condition; whether the recipient is ambulatory or recumbent; prevailing rates in the region; availability of transportation resources; level of appropriate transportation required; and whether they are transported by a family member, commercial carrier, or ambulance transporter.

Author: Dorothy Powell, Associate Director, Non-Emergency Transportation Program
Authority: State Plan; 42 C.F.R., Section 431.53; and Title XIX, Social Security Act.
Emergency rule effective January 1, 1996. Effective date of this rule March 14, 1996.
Amended: Filed June 21, 2010; Effective September 15, 2010.

Rule No. 560-X-18-.19. Administration of the NET Program.

(1) The Alabama Medicaid Agency staff, including Regional NET Coordinators and Central Office staff, serve as the point of contact and assist with scheduling the least expensive appropriate NET on a statewide basis. Recipients must contact the Agency to request transportation assistance five days prior to the needed transportation or within 24 hours after urgent care appointments. The Alabama Medicaid Agency arranges necessary non-emergency transportation services for Medicaid recipients. The responsibilities of the NET Program include, but are not limited to, the following:

(a) Determine availability of free transportation; this includes recipient's vehicle, transportation by relative or friend or volunteer services. Medicaid reimbursements are not awarded if recipient has access to free transportation, except in the case of evident hardship.

(b) Determine mileage reimbursement for recipient's vehicle or friend, relative or volunteer driver.

(c) Determine evident hardship.

(d) Verify eligibility; no reimbursement is available for transportation to/from non-covered medical services.

(e) Verify scheduled medical appointment.

(f) Determine the least costly appropriate means of transportation services.

(g) Assign prior authorization number

(h) Coordinate in-state and out-of-state commercial bus, train, or air transportation; Approve the use of commercial buses, trains or airplanes for in-state and out-of-state use for Medicaid recipients.

(i) The Alabama Medicaid Agency may issue a travel reimbursement through Electronic Benefit Transfer (EBT) for the cost of fare for recipients who are able to ride public transportation to medical services; public transportation should be utilized whenever possible; before other modes of more expensive transportation are authorized, there should be a determination that public transportation cannot meet the recipient's needs.

(j) Issue reimbursements to the recipient or redirect the reimbursement on behalf of the recipient to an address determined to be more appropriate than the address on file

(k) Compile information on all certified and licensed transporters.

(l) Complete retrospective utilization review of transportation reimbursements issued.

(2) Alabama NET Program is operated by Agency staff as an administrative service. Alabama provides for methods of administration that are necessary for the proper and efficient operation of the program.

Author: Dorothy Powell, Associate Director, Non-Emergency Transportation Program
Authority: State Plan; 42 C.F.R., Section 431.53; and Title XIX, Social Security Act.
Emergency rule effective January 1, 1996.Effective date of this rule March 14, 1996. **Amended**: Filed June 21, 2010; Effective September 15, 2010.

Rule No. 560-X-18-.20. NET Escorts.

(1) An escort is defined as an individual, other than an employee of a Transporter, whose presence is required to assist a recipient during transport and while at the place of treatment. An escort is typically a relative, guardian, or volunteer. Only one escort is covered per recipient in need and there must exist an identifiable need for the escort. Escort services are utilized in-state or out-of-state for recipients over 21 years of age only when a physician’s statement documents that an escort is required because the recipient is blind, deaf, mentally retarded, or mentally ill or physically handicapped to such a degree personal assistance is necessary.

(2) Escorts are allowed for recipients under the age of 21.

(3) The Alabama Medicaid Agency must obtain a medical certification statement from the individual requesting an escort for recipients age 21 and over before reimbursement can be made. The certification must document that the recipient is physically or mentally challenged, such as:

(a) blind;
(b) deaf;
(c) mentally retarded;
(d) mentally ill; or

(e) physically handicapped to such a degree that personal assistance is necessary.

(4) Escort services for commercial bus, train,and airplane transportation are reimbursed for the actual cost of the bus, train, or plane ticket.

(5) Meals and lodging, when overnight travel is necessary, for the recipient and one escort when an escort is required and authorized. Receipts or confirmation of expenses are required before reimbursement can be made. In no case will reimbursement exceed $50.00 per person, per day.

Author: Dorothy Powell, Associate Director, Non-Emergency Transportation Program
Authority: State Plan; 42 C.F.R., Section 431.53, and Title XIX, Social Security Act.
Emergency rule effective January 1, 1996. Effective date of this rule March 14, 1996.
Amended: Filed June 21, 2010; Effective September 15, 2010.

Rule No. 560-X-18-.21. Scope of NET Services.

(1) NET reimbursements will be issued for transportation costs to and from covered necessary medical services for which the recipient has benefits available as defined at 42 CFR 440.210 including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), inpatient hospital services, outpatient hospital services, Federally Qualified Health Center (FQHC), rural health clinic services, laboratory and x-ray services, breast and cervical cancer services, physician services, medical and surgical services of a dentist, medical equipment (e.g. orthotic and prosthetic), and pregnancy/family planning services.

Author: Dorothy Powell, Associate Director. Non-Emergency Transportation Program
Authority: State Plan; 42 C.F.R., Section 431.53; and Title XIX, Social Security Act.
Emergency rule effective January 1, 1996. Effective date of this rule March 14, 1996.
Amended: Filed June 21, 2010; Effective September 15, 2010.

Rule No. 560-X-18-.22. Modes of NET.

(1) Net services may be provided by one or more of the modes listed below when the recipient's medical care is necessary and the recipient has no other transportation resources. The least costly mode of transportation appropriate to the needs of the recipient must be used. This section includes all services covered by the NET Program:

(a) Automobile (volunteer driver); multiple passenger transportation is encouraged. Volunteer drivers can be reimbursed from the recipient's home (or place of admission or discharge) and return, unless Medicaid determines paying for additional mileage is the most economical transportation;

(b) Transportation provided by relatives or individuals living in the same household with the Medicaid recipient;

(c) Transportation provided in the Medicaid recipient’s vehicle or relative’s vehicle;

(d) minibus services;

(e) wheelchair vans services. Escorts are allowed for wheelchair vans when prior approved by the Alabama Medicaid Agency;

(f) bus (commercial or city transit); this service may be provided in-state or out-of-state;

(g) airplane transportation will be reimbursed for in-state or out-of-state service;

(h) train service may be provided in-state or out-of-state;

(i) ambulance.

Author: Dorothy Powell, Associate Director, Non-Emergency Transportation Program
Authority: State Plan; 42 C.F.R., Section 431.53; and Title XIX, Social Security Act.
Emergency rule effective January 1, 1996. Effective date of this rule March 14, 1996.
Amended: Filed June 21, 2010; Effective September 15, 2010.

Rule No. 560-X-18-.23. NET Service Limitations.

(1) A maximum of one round trip may be reimbursed per date of service per recipient, without prior authorized exception.

Author: Dorothy Powell, Associate Director, Non-Emergency Transportation Program
Authority: State Plan; 42 C.F.R., Section 431.53; and Title XIX, Social Security Act.
Emergency rule effective January 1, 1996. Effective date of this rule March 14, 1996.
Amended: Filed June 21, 2010; Effective September 15, 2010.

Rule No. 560-X-18-.24. Non-covered NET Services.

(1) When appropriate free transportation is available.

(2) any travel when the Medicaid recipient is not an occupant of the vehicle unless that would be the most economical transportation available;

(3) meals and lodging for volunteer drivers;

(4) the use of supplies such as oxygen, intravenous fluids, etc.;

(5) transportation for any services other than those covered by Medicaid;

(6) transportation provided after the death of a Medicaid recipient;

(7) minibus or wheelchair van travel outside a 30-mile radius of the state boundary;

(8) services for which prior approval is required but not obtained; and

(9) services are not medically necessary or which are not provided in compliance with the provision of this chapter.

Author: Dorothy Powell, Associate Director Non-Emergency Transportation Program

Authority: State Plan; 42 C.F.R., Section 431.53; and Title XIX, Social Security Act.
Emergency rule effective January 1, 1996. Effective date of this rule March 14, 1996.
Amended: Filed June 21, 2010; Effective September 15, 2010.

Chapter 19. Hearing Services

Rule No. 560-X-19-.01. Hearing Services – General.

1. Audiological function tests and hearing aids are limited to Medicaid eligible individuals who are eligible for treatment under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Hearing aids are provided through hearing aid dealers who are contracted to participate in the Alabama Medicaid Hearing Aid Program.
2. An eligible individual with hearing problems may be referred to a private physician or to Crippled Children's Service for medical evaluation. Audiological function tests must be referred by a physician before testing.
3. Medical Examination:
   - (a) A hearing aid will not be approved for any Medicaid eligible recipient prior to a medical examination and recommendation for a hearing evaluation by a licensed physician, within sixty (60) days of the time of hearing aid fitting. This is mandatory.
   - (b) The medical examination should, if possible, be given by a physician specializing in diseases of the ear. If a physician of this type is not available or accessible, referral may be made to Crippled Children Service for otological evaluation, medical clearance and medical approval for the use of earmolds.
   - (c) Children under six (6) years of age shall be examined by an otologist or otolaryngologist before an aid is fitted.
   - (d) The examining physician referring the patient to a hearing aid dealer will be required to furnish the dealer with appropriate medical evaluation statements and recommendations, according to program requirements.
4. Otologic Evaluations: Eligible recipients are authorized one otologic evaluation per calendar year, which shall include one of the following: a. Basic comprehensive audiometry, b. Evoked response audiometry, c. Conditioning play audiometry. Prior authorization is not required for additional evaluations within the current benefit period.
5. Special Audiological Function Tests. Special audiological function tests are those services not included in a comprehensive evaluation. These services are reported separately using discriptors from the audiological series of the CPT manual. Prior authorization is not required.

Authority: State Plan; 42 C.F.R. Title XIX, Social Security Act; 42 C.F.R. Section 441.56. Rule effective October 1, 1982. Amended June 8, 1985. Effective date of emergency rule is December 1, 1986. Effective date of amendment March 12, 1987. Effective date of emergency rule is October 1, 1990. Effective date of emergency rule is March 18, 1991. Effective date of this amendment is June 12, 1991.

Rule No. 560-X-19-.02. Participation and Enrollment Requirements.

1. Only in-state and borderline out-of-state (within 30-mile radius of state line) audiology and hearing aid providers who meet enrollment requirements are eligible to participate in the Alabama Medicaid program.
2. Audiology providers: Must hold a valid current State license issued by the state in which they practice. Since licenses are reviewed annually Medicaid will review reference sources such as the Board of Examiners for Speech Pathology and Audiology for determining an audiologist's professional qualifications.

3. Medicaid's fiscal agent is responsible for enrollment of audiologists. Licensed audiologists desiring to participate in the Alabama Medicaid Program should furnish the following information in a written enrollment request to Medicaid's Fiscal Agent.
   (a) Name
   (b) Address
   (c) Specialty provider type
   (d) Social Security Number
   (e) Tax ID Number
   (f) Copy of current State license
4. Hearing Aid Dealers - must hold a valid current license issued by the Alabama Board of Hearing Aid Dealers, as issued by the state in which the business is located. Licensed hearing aid dealers desiring to participate in the Alabama Medicaid Program are required to enter into a contractual agreement with the Alabama Medicaid Agency. The dealer should request a contract agreement from the Associate Director of the Hearing Services Program, Alabama Medicaid Agency.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services

Statutory Authority: State Plan; 42 C.F.R. Title XIX, Social Security Act; 42 C.F.R. Section 441.56.

History: Rule effective October 1, 1982, July 9, 1984, October 1, 1990, March 18, 1991, and June 12, 1991. Amended: Filed October 19, 2001; effective February 11, 2002.

Rule No. 560-X-19-.03. Billing Procedures and Claims Payment.

1. Audiologists and hearing aid dealers should refer to Rule 560-X-1-.17, Chapter One, Administrative Code, for provider billing instructions.
2. Claims forms and billing instructions will be furnished to participating providers by Medicaid's fiscal agent.
3. An audiologist employed by a physician cannot file a claim for the same services billed by that physician for the same patient, on the same date of service.
4. Providers may bill an Alabama Medicaid recipient only when the recipient has exhausted all of his/her allowed Medicaid benefits or when the service rendered is a non-covered service.

Authority: State Plan; 42 C.F.R. Section 401, Et seq.; Title XIX, Social Security Act. Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Emergency rule effective March 18, 1991. Effective date of this amendment is June 12, 1991.

Chapter 20. Third Party

Rule No. 560-X-20-.01 Third Party Program.

1. General
   - (a) Third Party Division (TPD), Alabama Medicaid Agency, is responsible for fulfilling the requirements pertaining to third party liability. The purpose of the TPD is to insure that Medicaid is the last payor.
   - (b) Third party resources are primary to Medicaid.
   - (c) Federal law requires that state Medicaid agencies take all reasonable measures to identify third party resources which may have legal/fiscal/contractual liability as a result of medical assistance furnished to a Medicaid recipient.
   - (d) Where third party liability is known or reasonably expected, the Medicaid Agency may require providers to collect third party resources prior to filing Medicaid.
   - (e) Where Medicaid payment has not been reduced by third party benefits, the Medicaid Agency is required to take reasonable measures to collect from third parties the cost of medical assistance furnished to Medicaid recipients to the extent that the third party may have legal/fiscal/contractual liability.
   - (f) Claims for services which are filed with Medicaid and paid in full or in part by a third party will be applied against program benefit limitations.
   - (g) A provider may not refuse to furnish services covered under the plan to an individual who is eligible for Medicaid under the plan due to a third party's potential liability for the service(s).
2. Definitions
   - (a) Third Party - Any individual, entity or program that is or may be liable (contractually or otherwise) to pay all or part of the medical cost of any medical assistance furnished to a recipient under a State plan.
   - (b) Private insurer - a third party which may be:
     1. Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);
     2. Any profit or nonprofit prepaid plan (including, but not limited to, subscription plans) offering either medical services or full or partial payment for services included in the State Plan;
     3. Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.
   - (c) Employer Drug Program - A specific program offered through a group health plan which provides benefits for prescription drugs. The program covers the prescription in full if provided by a pharmacist participating in the program; there is a co-payment required of the insured for prescriptions received from a non-participating pharmacy. The drug program pays directly to pharmacies which participate in the program; it pays benefits to the insured for prescriptions dispensed by a non-participating pharmacy. Under this program a drug card is issued through the group plan to the insured.
   - (d) Third party benefit - any benefit that may be available at any time through contract, court award, judgment, settlement, or agreement.

Authority: 42 CFR Section 432, 433, and 447.20; Section 1902(a)(25), Social Security Act; Section 22-6-6, Code of Alabama, 1975. Rule amended March 11, 1985, October 9, 1985, March 24, 1986, June 9, 1986, and January 13, 1993. This amendment effective July 13, 1993.

Rule No. 560-X-20-.02. Third Party Recovery.

1. General
   - (a) All providers must file claims with a third party as specified by this rule.
   - (b) Providers must file claims with a primary third party within sufficient time for the third party to make payment. If the provider has difficulty obtaining a response from the third party or with the processing of Medicaid claims due to Third Party procedures, the provider should contact the Third Party Division, Alabama Medicaid Agency.
   - (c) An aged, outdated claim which is timely submitted to Medicare or another third party must be received by the fiscal agent within one hundred twenty (120) days of the notice of the disposition of such claim to the provider.
   - (d) Providers cannot file with Medicaid until the third party responds. Exception: Providers may file Medicaid and Medicare simultaneously if the Medicare intermediary crosses over claims to the Medicaid fiscal agent.
2. Health Insurance Resources
   - (a) All providers (except as excluded through HCFA - approved cost avoidance waivers) are required to file for and obtain available third party health insurance benefits for all services except those excluded from cost avoidance requirements by federal regulations.
   - (b) Claims for services exempted by federal regulations from cost avoidance will not be denied by Medicaid due to available third party resources when the provider does not file with the third party. Such claims will be filed with the third party by the Medicaid Agency which will seek reimbursement of its payment from the third party.
   - (c) HCFA has approved a cost avoidance waiver for prescription drug claims; therefore, pharmacy providers are required to file for third party health insurance benefits prior to filing Medicaid only when
     1. the recipient is covered through a prescription drug plan of an employer group health insurance program. (See Rule No. 560-X-20-.01.); or
     2. the recipient's prescriptions are covered by the Veterans Administration.
3. Casualty and Other Third Party Resources
   - (a) All providers are required to file for liability insurance and other third party benefits if the recipient is insured with the plan as well as for worker's compensation benefits.
   - (b) The Third Party Division, Alabama Medicaid Agency, will file for third party benefits in situations where there is a third party other than the recipient's insurance and an injury is involved. Medicaid will file for casualty related resources to insure that all related medical care paid by Medicaid will be considered in a settlement.
   - (c) If a provider files with a third party resource other than the recipient's own insurance, the provider must notify the Third Party Division, Alabama Medicaid Agency, within five days of filing with the third party.
   - (d) Providers may file liens when there are charges not covered by Medicaid; however, the provider must furnish to the Third Party Division, Alabama Medicaid Agency, complete information about the lien within five days of filing the lien.

Authority: 42 CFR Section 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama; 42 CFR Section 447.45; Title XIX, Social Security Act. Rule effective October 1, 1982. Amended March 11, 1985, April 11, 1986, May 11, 1987. Effective date of this amendment January 13, 1993.

Rule No. 560-X-20-.03. Documentation of Third Party Resources.

1. The Claim
   (a) All providers are required to question Medicaid recipients to obtain information about third party resources which may pay as a result of medical services provided to the recipient. All providers must complete third party fields on the Medicaid claim, including stating the name, address, and policy number of any third party resource.
2. Form XIX-TPD-1-76
   (a) All providers except as noted herein are required to submit a completed Form XIX-TPD-1-76 with their Medicaid claim if one or more of the following conditions are met:
   (b) Treatment was due to an injury
   (c) There is a third party resource not billed by the provider.
   (d) Radiologists, Pharmacists, Pathologists, Ambulance providers, Anesthesiologists, Nursing Homes, Home Health agencies, and Children's Rehabilitation Services providers are not required to submit form XIX-TPD-1-76 with their claims.
   (e) Form XIX-TPD-1-76 is not required if treatment is due to disease or a home injury where there is no potential third party liability; however, the claim must state "home injury" or "treatment due to disease". Injuries received by a patient in a nursing home are not home injuries.
3. The Medicaid Eligibility File
   (a) The Third Party Division, Alabama Medicaid Agency, is required to show the existence of third party health insurance resources on the Medicaid Eligibility File. These codes are used in claims processing.
4. The Policy File
   (a) The Third Party Division, Medicaid, maintains a Policy File which identifies specific coverage provided by a recipient's health insurance.
5. AVRS and MACSAS
   (a) Third party benefit data is maintained on Medicaid's Automated Voice Response System and the Medicaid Automated Claim Submission and Adjudication System for inquiry by providers. Providers should access either system for third party health insurance information prior to filing Medicaid.

Authority: 42 C.F.R. Section 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama. Effective date of this amendment January 13, 1993.

Rule No. 560-X-20-.04. Third Party Payments/Denials.

1. Third Party Payments other than Medicare
   (a) Third Party payments must be applied to the services for which the third party paid.
   (b) Providers receiving a third party payment prior to filing Medicaid must document in the appropriate field on the claim the amount of the third party payment.
   (c) Providers receiving a third party payment after Medicaid is filed must within 60 days of receiving duplicate payment:
      1. send a refund of the insurance money to the Third Party Division, Alabama Medicaid Agency; or
      2. write the Medicaid fiscal agent and request an adjustment of Medicaid payment (a copy of the request MUST be sent to the Third Party Division, Alabama Medicaid Agency).

(d) If the third party pays the recipient or source other than the provider, the provider is responsible for obtaining the third party payment prior to filing Medicaid. The provider is responsible for reimbursing Medicaid if a third party pays the recipient or source other than the provider for Medicaid covered services if the third party makes payment as a result of information released by the provider.

(e) If the provider accepts a patient with a third party resource as Medicaid the provider cannot bill the patient for Medicaid covered services if:

1. the third party pays more than Medicaid allows which results in Medicaid not making payment.
2. the claim is denied by Medicaid because of third party resources and the recipient furnishes in a timely manner third party information.

(f) A provider may bill a Medicaid patient if Medicaid denies a claim because of available third party benefits and the provider cannot obtain information needed to file a third party claim from the recipient, AVRS, MACSAS or the Medicaid Agency.

2. Third Party Payments - Medicare

(a) Providers must attach a copy of the Medicare EOMB to the Medicaid claim.

(b) Within 60 days of receiving duplicate Medicaid and Medicare payments the provider must:

1. Refund the Medicaid payment to the Medicaid fiscal agent and state the reason for the refund; or
2. Request that the Medicaid fiscal agent adjust the Medicaid claim.

3. Third Party Denials

(a) Providers must attach third party denials of benefits to their Medicaid claim when filing for Medicaid benefits. These claims must be filed as paper claims.

(b) Providers must state on the Medicaid claim "Denied by Third Party" if third party benefits are denied.

(c) Only true denials of benefits are acceptable, i.e., policy has lapsed, benefits applied to deductible, non-covered services, etc.

4. Questions regarding third party payment/denials should be referred to the Third Party Division, Alabama Medicaid Agency.

Authority: 42 C.F.R. Sections 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama. Effective date of this amendment January 13, 1993.

Rule No. 560-X-20-.05. Release of Information - All Providers.

1. Information pertaining to a patient's treatment (including billing statement, itemized bills, etc.) may be routinely released ONLY UNDER THE FOLLOWING CIRCUMSTANCES AND/OR TO THE FOLLOWING AGENCIES if Medicaid has been billed or is expected to be billed:

(a) The Medicaid Fiscal Agent,

(b) The Social Security Administration,

(c) The Alabama Vocational Rehabilitation Agency,

(d) The Alabama Medicaid Agency,

(e) Requests from insurance companies for information pertaining to a claim filed by the provider in accordance with Medicaid Regulations and for which an assignment of benefits to the provider was furnished the insurance company.

(f) Requests by insurance companies for information to process an application for insurance, to pay life insurance benefits, or to pay on a loan.

(g) Requests from other providers for medical information needed in the treatment of patient.

2. If information pertaining to a patient's treatment is requested by any other source, or under any other circumstance, the Alabama Medicaid Agency, Third Party Section, must be contacted PRIOR TO RELEASE OF INFORMATION. The only exception is when a subpoena is received during nonworking hours of the Alabama Medicaid Agency and must be responded to immediately. Should this occur, the provider may respond to the subpoena and must include with the released records a notice that the patient was covered by Medicaid. In addition, the provider must notify the Third Party Section of the subpoena as soon as possible.
3. It is not the intention to deny release of information; however, requests for information pertaining to a recipient's charges are a source of third party information and, as such, must be reviewed by the Third Party Section.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Section 22-6-6 of 1975 Code of Alabama.

Rule No. 560-X-20-.06. Fiscal Agent Responsibility.

1. The fiscal agent is responsible for monitoring all claims for possible third party liability and utilizing information on the face of the claim, Form XIX-TPD-1-76, the Eligibility file, the Insurance Policy File, and Diagnostic Codes to identify potential third party liability.
2. The fiscal agent is responsible for retroactively identifying third party liability on a regular basis.
3. Where it is determined a recipient is retroactively eligible for Medicare, the fiscal agent will recoup erroneous Medicaid payment from the provider and instruct the provider to file with Medicare.

Authority: 42 C.F.R. Sections 432 & 433; Section 1902(a)(25), Social Security Act; Section 22-6-6 of 1975 Code of Alabama.

Rule No. 560-X-20-.07. Recipient Responsibility.

1. The Alabama Medicaid Agency by statute is subrogated to the rights of a Medicaid recipient against any third party arising out of injury, disease, or sickness. The recipient is required to assist and cooperate fully with Alabama Medicaid Agency in its effort to secure such rights including the requirement to:
   - (a) Notify Alabama Medicaid Agency within ten days of filing suit against a third party;
   - (b) Notify Alabama Medicaid Agency, Third Party Section, prior to entering any settlement with a third party;
   - (c) Immediately pay to Alabama Medicaid Agency all funds received from any third party to the extent necessary to satisfy the subrogation rights of the State of Alabama;
   - (d) Disclose information regarding health insurance or other third party resources when applying for Medicaid;
   - (e) Notify providers of medical care of health and casualty coverage and other third party resources when requesting medical care;
   - (f) Notify Alabama Medicaid Agency of any health insurance obtained after becoming eligible for Medicaid;
   - (g) Notify Alabama Medicaid Agency, Third Party Section, of any casualty/liability insurance which may cover medical treatment received due to an injury;
   - (h) Execute and deliver all instruments and papers needed by Alabama Medicaid Agency in pursuit of its subrogation claim.
2. The State of Alabama by statute is assigned any and all rights to payments by any person, firm or corporation which result from medical care received by the recipient, together with the rights of any other individuals eligible for Medicaid for whom he can make assignment. This assignment shall be effective to the extent of the amount of medical assistance actually paid by the Agency and shall, effective 11/9/84, exclude Medicare. The recipient is required to assist and cooperate fully with Alabama Medicaid Agency in its effort to secure such rights.

3. Failure of the applicant or recipient to cooperate with the Medicaid Program to secure its rights to subrogation and assignment may result in denial or termination of Medicaid eligibility. Recipients terminated under this Rule will be notified in writing of the agency action and afforded the opportunity for a Fair Hearing under the provisions of Chapter 3 of these Rules.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Code of Alabama Sections 22-6-6 & 22-6-6.1. Rule effective October 1, 1982. Effective date of amendment February 9, 1987.

Rule No. 560-X-20-.08. Payment of Health Insurance Premiums.

1. The Alabama Medicaid Agency may pay health insurance premiums of certain Medicaid eligibles or recipients when the Agency determines that payment of the premium would be cost effective. The primary objective of paying certain health insurance premiums is to reduce Medicaid expenditures by enrolling Medicaid eligibles in or continuing existing health insurance coverage so that Medicaid becomes a secondary payor.
2. Cost effectiveness is defined as meaning the expenditure of Medicaid funds for a set of services is likely to be greater than the cost of paying the health insurance premium. Criteria for determining cost effectiveness will be determined by the Alabama Medicaid Agency.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Consolidated Omnibus Reconciliation Act of 1985; Section 4402 of the Omnibus Reconciliation Act of 1990. Emergency rule effective April 1, 1991. Effective date of this amendment August 16, 1991.

Chapter 21. Nurse Midwife Program

Rule No. 560-X-21-.01. Legal Authority for the Nurse Midwife Program.

1. Alabama Law provides rules under which properly trained nurses can be licensed to practice the profession of Nurse Midwifery (Alabama Code, Section 34-19-2, et seq.).

2. Federal Law (Title XIX, Sections 1905[a][17] and [m]) requires that the Medicaid Program in each state include the services of nurse midwives as a mandated service.

3. These regulations state the conditions under which the services of nurse midwives are covered by the Medical Assistance Program of the Alabama Medicaid Agency.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Sections 440.210, 440.165, 441.220, and 441.21. Code of Alabama, Section 34-19-2, et seq. Rule effective October 1, 1982. Emergency amendment June 14, 1993. Amended August 12, 1993. Effective date of this amendment March 15, 1994.

Rule No. 560-X-21-.02. General.

1. Providers in this program are limited to persons who are licensed as "Registered Nurse" and who are also licensed as "Certified Nurse Midwife."

2. Nurse Midwifery practice is defined as the management of care for normal healthy women and their babies in the areas of prenatal; labor and delivery; postpartum care; well-woman gynecology, including family planning services; and normal newborn care.

3. The practice of Nurse Midwifery must be done under appropriate physician supervision.

4. The services provided by nurse midwives must be within the scope of practice authorized by state law and regulations.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Sections 440.165, and 441.21. Code of Alabama Section 34-19-2 et seq. Rule effective October 1, 1982. Emergency amendment June 14, 1993. Amended August 12, 1993. Effective date of this amendment March 15, 1994.

Rule No. 560-X-21-.03. Participation.

1. In order to participate in the program a nurse midwife must complete an enrollment application, be approved for enrollment, sign a contract, and be issued a provider number.

2. Only in-state and borderline out-of-state (within a 30-mile radius of Alabama's state line) providers who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program.

3. Nurse Midwives who want to participate in the Medicaid program should contact the Medicaid Agency for an enrollment application. Send the request to:

Administrator of Nurse Midwife Program
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

4. The completed application form along with a copy of current registered nurse and nurse midwife licensure, plus a copy of the written signed agreement between the nurse midwife and the physician consultant should be returned to the same address at the Alabama Medicaid Agency. If the application is approved, Medicaid will offer the applicant a one-year renewable contract.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Sections 401, et seq., 440.165, 441.21; Code of Alabama Section 34-19-2, et seq. Rule effective October 1, 1982. Effective date of this emergency amendment June 14, 1993. Effective date of this amendment August 12, 1993.

Rule No. 560-X-21-.04. Reimbursement.

1. Nurse midwives may submit claims and be reimbursed only for those procedure codes authorized by Medicaid policy. Claims should be submitted on a Health Insurance (HCFA 1500) Claim Form.

2. The nurse midwife agrees when billing Medicaid for a service that the midwife will accept as payment in full, the amount paid by Medicaid for the services and that no additional charges will be made.

3. Conditional collections from patients, made before Medicaid pays, to be refunded after Medicaid reimbursement for the service, are not permissible.

4. A hospital-based nurse midwife who is employed by and paid by a hospital may not bill Medicaid for services performed therein and for which the hospital is reimbursed. A nurse midwife who is not employed by and paid by a hospital may bill Medicaid using a Health Insurance (HCFA 1500) Claim Form. To prevent double payment, the nurse midwife having a Medicaid provider number(s) shall inform the Alabama Medicaid Agency of the name of the hospital(s) with whom employed, regardless of regularity and frequency.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Sections 440.165, 440.210, 440.220, and 441.21; Code of Alabama, Section 34-19-2, et seq. Rule effective October 1, 1982. Amended July 10, 1987 and February 9, 1989. Emergency amendment June 14, 1993. Amended August 12, 1993. Effective date of this amendment March 15, 1994.

Rule No. 560-X-21-.05. Covered Services.

1. The maternity services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a nurse midwife provides total obstetrical care, the procedure code which shall be filed on the claim form is the code for all inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery. If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time she is eligible will be covered. When a nurse midwife provides eight (8) or more prenatal visits, performs the delivery, and provides postpartum care, he/she shall use a "global" obstetrical code in billing the services. If a nurse midwife submits a "global" code for maternity services, the visits covered by this code are not counted against the recipient's limit of physician office visits per calendar year. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

a. Antepartum care includes all usual prenatal services such as initial office visit, at which time the pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling, etc.; therefore, additional claims for routine services shall not be filed. Antepartum care also includes routine lab work (i.e.; hemoglobin, hematocrit, and chemical urinalysis); therefore, additional claims for routine lab work should not be filed.

    1. In order to bill for Antepartum Care Only services, nurse midwife providers must utilize the appropriate procedure codes when billing for the services (i.e., CPT code 59425 for four to six visits or CPT code 59426 for seven or more visits). Antepartum Care Only services filed in this manner do not count against the recipient's annual office visit benefit limits. Nurse Midwives who provide less than four visits for antepartum care must use office visit procedure codes when billing for the services. The office visit procedure codes will be counted in the recipient's annual benefit limits for office visits.

b. Delivery shall include vaginal delivery (with or without episiotomy) and postpartum care or vaginal delivery only services. The nurse midwife will utilize the appropriate CPT code when billing delivery services. More than one delivery fee may not be billed for a multiple birth (i.e.; twins, triplets, etc.). Delivery fees include all professional services related to the hospitalization and delivery services provided by the nurse midwife. Additional claims for the nurse midwife's services in the hospital (e.g., admission) may not be filed. EXCEPTION: When a nurse midwife's first and only encounter with the recipient is for delivery ("walk-in" patient) he/she may bill for a hospital admission (history and physical) in addition to delivery charges.

c. Postpartum care includes office visits following vaginal delivery for routine postpartum care within sixty (60) days post delivery. Additional claims for routine visits during this time should not be filed. Family Planning services preformed by the delivering provider on the day of the postpartum exam or within five (5) days of the postpartum exam are noncovered as they are included in the postpartum exam.

d. If the provider does not perform the delivery, but does provide the postpartum care, family planning services rendered within five (5) days of the postpartum exam are noncovered, as they are included in the postpartum exam.

2. Family planning services include services that prevent or delay pregnancy such as office visits for evaluation and management of contraceptive issues, including procedures and supplies as appropriate for effective birth control. Nurse Midwives are not authorized to do sterilization procedures. Other surgical procedures; such as diaphragm fittings, IUD insertions or removals, and contraceptive implant procedures; are covered when provided according to state laws and regulations.

3. The nurse midwife may provide and be reimbursed for well-woman gynecological services including the evaluation and management of common medical and/or gynecological problems such as menstrual problems, Pap smear screenings, menopausal and hormonal treatments, treatment of sexually transmitted diseases, and treatment of minor illnesses (e.g., a minor pelvic inflammatory disease).

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Sections 440.165, 440.210, 440.220, and 441.21; Code of Alabama, Section 34-19-2, et seq. Emergency rule effective June 14, 1993. Rule effective August 12, 1993. Effective date of this amendment March 15, 1994.

Rule No. 560-X-21-.06. Required Written Records.

1. When a patient is accepted for maternity services, the midwife's care must include plans for a delivery to be accomplished in a licensed hospital. In an emergency, delivery may be accomplished elsewhere. The plans need not be submitted to Medicaid but the midwife's file should contain written evidence that such plans existed for each patient accepted for global care.

2. All nurse midwife services must be rendered under appropriate physician supervision. The physician may not bill for these supervisory services. The written records that each midwife keeps should include records naming the physician(s) with whom she works, and stating the working arrangement with the physician. The statement of the working arrangement need not be a formal contract, but it must contain the signature of both parties and must show the date on which it was signed.

3. A complete medical record shall be maintained for each recipient for whom the nurse midwife provides services.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 441.21; Code of Alabama Section 34-19-2, et seq. Rule effective October 1, 1982. Emergency amendment June 14, 1993. Amended August 12, 1993. Effective date of this amendment March 15, 1994.

Rule No. 560-X-21-.07. Payments to Physicians.

1. The supervising physician may not bill for supervisory services. The physician can bill Medicaid, however, if it becomes necessary for the physician to perform the delivery or complete a delivery service for the nurse midwife. When the physician bills the delivery only service, the midwife may bill antepartum care or postpartum care, or both, depending on which service(s) the nurse midwife performed. If the physician bills for delivery only including postpartum care, the nurse midwife may bill only for the antepartum care provided.

2. Sterilization at the time of delivery is covered by Medicaid only if it is performed by the physician, and only if all other Medicaid requirements for sterilization are met.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 441.21; Code of Alabama Section 34-19-2, et seq. Rule effective October 1, 1982. Emergency amendment June 14, 1993. Amended August 12, 1993. Effective date of this amendment March 15, 1994.

Rule No. 560-X-21-.08. Third Party Requirements.

Nurse Midwives are required to identify recipients who are covered by third party resources and to obtain payment from those resources in accordance with Chapter 20 of the Medicaid Agency's Administrative Code.

Authority: Title XIX, Social Security Act, Section 1902(a)(25); 42 C.F.R., Section 401; Code of Alabama, 1975, Section 22-6-6. Effective date of this emergency rule June 14, 1993. Rule effective August 12, 1993.

Rule No. 560-X-21-.09. Billing of Medicaid Recipients.

1. A provider may bill Medicaid recipients for any noncovered service or for services provided to a recipient who has exhausted annual benefits.

2. Billing the recipient for services not paid by Medicaid due to provider correctable errors on claims submission or untimely filing is not permissible.

3. Medicaid recipients are exempt from co-payment requirements for maternity care and family planning services.

4. Co-pay requirements apply to well-woman gynecological office services, except for those recipients under the age of 18.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.15, et seq. Emergency rule effective June 14, 1993. Rule effective August 12, 1993. Effective date of this amendment March 15, 1994.

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Chapter 22. Nursing Facility Reimbursement Program

Rule No. 560-X-22-.01. Nursing Facility Reimbursement – Preface.

This Regulation states the Medicaid policy regarding nursing facility reimbursement and establishes the accepted procedures whereby reimbursement is made to nursing facility providers. Because of the length and complexity of this Chapter, it has been divided into sections to facilitate its utilization.

Authority: Code of Alabama, 41-22-2

Rule No. 560-X-22-.02. Introduction.

1. This Chapter of the Alabama Medicaid Regulations has been promulgated by the Alabama Medicaid Agency, Medicaid, for the guidance of providers of Medicaid nursing facility care. This Chapter is applicable to those providers categorized as NF, NF/IMD, and NF/IDD. It does not apply to those providers categorized as ICF/MR.

2. The Alabama Medicaid Program is administered by Medicaid under the direction of the Governor's Office. Reimbursement principles for nursing facilities are outlined in the following sections of this Chapter. These principles, hereinafter referred to as "Medicaid Reimbursement Principles," are a combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and principles and procedures promulgated by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated nursing facilities. These principles are not intended to be all-inclusive, and additions, deletions, and changes to them will be made by Medicaid on an annual basis, or as required. Providers are urged to familiarize themselves fully with the following information, as cost reports must be submitted to Medicaid in compliance with this regulation.

3. If this Regulation is silent on a given point, Medicaid will normally rely on Medicare (Title XVIII) Principles of Retrospective Reimbursement and, in the event such Medicare Principles provide no guidance, Medicaid may impose other reasonability tests. The tests include, but are not limited to, such tests as:

    a. Does the cost as reported comply with generally accepted accounting principles?

    b. Is the cost reasonable on its own merit?

    c. How does the cost compare with that submitted by similarly sized homes furnishing like category of care?

    d. Is the cost related to patient care and necessary to the operations of a nursing facility?

4. It is recognized that there are many factors involved in operating a nursing facility. The size of the facility, the intensity of care required, the geographical location (rural or urban), the available labor market, and the availability of qualified consultants are only examples of such factors, and considerable effort has been made to recognize such variables during the development of this Chapter. Only reported costs reflecting such variables without exceeding the "prudent buyer" concept or other applied tests of reasonability will be allowed by Medicaid. Medicaid will consider granting variances from the Medicaid Reimbursement Principles whenever a provider submits convincing evidence that it can provide a service in a more cost effective manner if such variance is permitted. Such evidence should be submitted to Chief Auditor, Provider Audit, for approval.

5. Records must be kept by the provider which document and justify costs, and only those costs which can be fully and properly substantiated will be allowed by Medicaid. Increases over amounts reported on a provider's previous cost reports, except those increases inherent in normal inflation, will be closely examined for reasonableness.

The principles presented herein are based on the "prudent buyer" concept. Nursing facility administrators are expected to conduct their business in an efficient and conservative manner, and to submit requests for reimbursement only for costs which are absolutely necessary to the conduct of an economically and efficiently operated nursing facility.

6. Unallowable costs which are identified during either desk audits or field audits will be disallowed despite similar costs having been included in prior cost reports without having been disallowed.

7. The only source of the funds expended by Medicaid is public funds, exacted from the taxpayers through state and federal taxes. Improper encroachment on these funds is an affront to the taxpayers and will be treated accordingly.

8. To assure only necessary expenditures of public money, it will be the policy of Medicaid to:

    a. Conduct on-site audits of facilities on an unannounced basis, although prior announcement may be made at the discretion of Medicaid.

    b. Determine audit exceptions in accordance with Medicaid Reimbursement Principles.

    c. Allow only non-extravagant, reasonable, necessary and other allowable costs and demand prompt repayment of any unallowable amounts to Medicaid.

9. In the event desk audits or field audits by Medicaid's staff reveal that providers persist in including unallowable costs in their cost reports, Medicaid may refer its findings to the Medicaid Investigation Section, Medicaid Counsel, and/or the Alabama Attorney General.

10. CAUTION: The cost allowances contained in this Chapter are maximum allowances, and are not considered a standard. Providers whose costs are normally and historically below the presented amounts may not automatically report the larger amount.

11. While the responsibility for establishing policies throughout the Medicaid Program rests with Medicaid, comments on the contents of this Chapter are invited and will be given full consideration.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.200 - .272. Rule effective October 1, 1982. Amended July 9, 1984, and October 11, 1986. Emergency rule effective May 1, 1988. Amended July 12, 1988 and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.03. Definitions.

1. Accrual Method of Accounting - Revenues must be allocated to the accounting period in which they are earned and expenses must be charged to the period in which they are incurred. This must be done regardless of when cash is received or disbursed.

2. Adjusted Reported Costs - The net reported costs from Schedule D, Column 7, of the cost report adjusted, as required, for unallowable costs, and cost recovery items.

3. Medicaid - The Alabama Medicaid Agency.

4. Medicaid Reimbursement Principles - A combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and procedures and principles promulgated by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated nursing facilities.

5. Allowable Costs - The costs of a provider of nursing facility services which must be incurred by an efficiently and economically operated facility and which are not otherwise disallowed by the reimbursement principles established under and incorporated into this Chapter.

6. Approved Bed Rate - The Medicaid rate paid to nursing facilities for approved beds. (See Section 5 for computation.)

7. Category - Grouping formed according to type of facility. Medicaid categories to which this Chapter applies are: NF, NF/IMD, and NF/IDD.

8. Chapter - This Chapter (Twenty-Two) of the Alabama Medicaid Agency Administrative Code.

9. Cost Recovery Item - Income generated by an element of allowable cost.

10. Facility - Any structure licensed by the State of Alabama for the purpose of providing long-term care to the aged, ill, or disabled.

11. Fair Market Value - The bona fide price at which an asset would change hands or at which services would be purchased between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of the relevant facts.

12. Fiscal Year - The 12 month period upon which providers are required to report their costs, being the period from July 1st through June 30th, also called the "reporting period."

13. HCFA - The Health Care Financing Administration, an agency of the U.S. Department of Health and Human Services.

14. HIM-15 - The title of the Medicare Provider Reimbursement Manual, a publication of HCFA. All references to this manual or to Title XVIII Principles of Reimbursement in Chapter 22 are for the "Retrospective" Reasonable Cost Reimbursement Principles and not those of the 10-1-83 Prospective Medicare System.

15. Hold Bed Days - The period during which a provider receives payment from a source other than Medicaid for the reservation of a bed in a long term care facility for a particular patient who is not in the facility. Hold bed days do not include therapeutic leave covered by Medicaid.

16. Home Office Costs - See Rule No. 560-X-22-.20 for in-depth discussion and treatment of home office costs.

17. Imprest System - A system in which any fund is replenished by writing a check equal to the payments which have been made out of the fund. Examples of such funds are petty cash and payroll.

18. Interest - Cost incurred for the use of borrowed funds.

    a. Necessary Interest - Incurred to satisfy a financial need of the provider on a loan made for a purpose directly related to patient care. Necessary interest cannot include loans resulting in excess funds or investments.

    b. Proper Interest - Must be necessary as described above, incurred at a rate not in excess of what a prudent borrower would have to pay in the money market at the time the loan was made, and incurred in connection with a loan directly related to patient care or safety.

19. Interim Per Diem Rate - A rate intended to approximate the provider's actual or allowable costs of services furnished until such time as actual allowable costs are determined.

20. Medicaid Occupancy - The percentage of the total patient days reported by a nursing facility utilized by patients whose stay is paid all or in part by Medicaid. This does not include Medicare co-pay days.

21. Medicaid Per Diem Rate - The amount paid by Medicaid for nursing facility services provided to Medicaid patients for a one-day period.

22. Necessary Function - A function being performed by an employee which, if that employee were not performing it, another would have to be employed to do so, and which is directly related to providing nursing facility services.

23. Patient Day - Any day that a bed is either occupied or is not otherwise available for immediate occupancy by a newly admitted patient, but only if some payment and/or promise of payment is received either at the full per diem rate or a reduced rate.

24. Proprietary Provider - Provider, whether a sole proprietorship, partnership, or corporation, organized and operated with the expectation of earning profit for the owners as distinguished from providers organized and operated on a non-profit basis.

25. Provider - A person, organization, or facility who or which furnishes services to patients eligible for Medicaid benefits.

26. Prudent Buyer Concept - The principle of purchasing supplies and services at a cost which is as low as possible without sacrificing quality of goods or services received.

27. Related - The issue of whether the provider and another party are "related" will be determined under the HIM-15 rules as to classification as "related" parties. (See HIM-15.)

28. Reasonable Compensation - Compensation of officers and/or employees performing a necessary function in a facility in an amount which would ordinarily be paid for comparable services by a comparable facility.

29. Reasonable Costs - Necessary and ordinary cost related to patient care which a prudent and cost-conscious businessman would pay for a given item or service.

30. State Plan - The State Plan promulgated by the State of Alabama under Title XIX of the Social Security Act Medical Assistance Program.

31. Straight Line Method of Depreciation - Depreciation charges spread equally over the estimated life of the asset so that at the expiration of that period the total cost that was determined to be recoverable through such charges has been recovered.

32. Unallowable Costs - All costs incurred by a provider which are not allowable under the Medicaid Reimbursement Principles.

33. Lease - An agreement in which the facility pays for the use of buildings or equipment. Such agreements must not meet the criteria for capitalization as outlined in HIM-15.

34. Nursing Facility/Institution for Mental Diseases - A nursing facility that provides care only for patients diagnosed with Mental Disease and are over sixty-five (65) years of age.

35. Nursing Facility/Institution for the Developmentally Disabled - A nursing facility that provides care only to physically and mentally disabled patients who are eighteen years of age or less.

36. Standard Value - A dollar value per bed used to cover the value of land, buildings, and major movable equipment.

37. Current Asset Value - Standard value per bed reduced by 1% for each year of age, limited to $12,500 per bed minimum.

38. Net Asset Value - Current asset value reduced by outstanding allowable mortgage debt.

39. Rebasing - A mechanism for reflecting inflation in land, buildings, and equipment costs.

40. Median - The middle value in a distribution, above and below which lie an equal number of values.

41. Operating Cost - Administrative and general expenses of running a nursing facility. See Section 560-X-22-.10 for a more detailed description.

42. Direct Patient Care Cost - Costs that are directly related to providing nursing care to a resident. They consist of direct nursing costs, raw food costs, and fees paid to medical directors, pharmacy consultants, dental consultants, and nursing consultants required by federal and/or state law.

43. Indirect Care Cost - All non-property costs not covered under operating costs and direct care costs. These costs consist of dietary costs (less raw food) housekeeping costs, plant operating costs, activity costs, social service costs, laundry costs (less the cost of doing patient personal laundry) and miscellaneous cost.

44. Fair Rental Cost - The cost associated with acquiring and using real property (land, buildings, and major movable equipment) not including interest expense, property taxes, and property insurance. See Section 560-X-22-.14 for more detail.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended January 4, 1984, March 12, 1988 and July 12, 1988. Emergency rule effective May 1, 1990. Amended August 14, 1990 and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.04. Nurses Continuing Education.

Mandated Continuing Education Units for nurses and in-service training for nurse aides will be an allowable cost in the direct cost center if it was received in the State of Alabama. All other education cost will be accounted for in the operating cost center.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.200 - .272, et seq. Rule effective August 12, 1992.

Rule No. 560-X-22-.05. Medicaid Per Diem Rate Computation.

1. The Medicaid Per Diem Rate will be determined under reimbursement methodology contained in this Chapter. (See Rule No. 560-X-22-.06.) The rates will be based on the cost data contained in cost reports (normally covering the period July 1 through June 30th). In order to allow adequate time for a provider to prepare and submit the cost report and for Medicaid to compute a new rate, each provider will be paid an interim per diem rate. This interim rate will cover the period July 1 through December 31. The interim rate shall be the lower of the latest allowable computed rate or the ceiling rate per day. The allowable rate per day shall be trended by the Alabama Medicaid trend factor. (See Rule No. 560-X-22-.07(4)) Providers will be paid a weighted per diem rate for the portion of the fiscal year remaining after the provider's new rates are established. The weighted per diem rate will be determined as outlined below:

2. To calculate the weighted per diem rate: Multiply the allowable per diem rates times twelve. Deduct from that product the interim per diem rate multiplied by the number of months paid. Divide the remainder by the number of months remaining in the fiscal year.

   a. Example 1. Provider's interim rate has been in effect for five (5) months. Provider's weighted rate will be in effect for seven (7) months:

      Allowable per diem rate
      for the year $ 50.00
      Interim rate paid $ 48.00
      Allowable per diem rate
      multiplied by 12 = $50.00 x 12 $600.00
      Deduct interim per diem rate
      multiplied by number of months
      paid = $48.00 x 5 - $240.00
      Remainder = $ 360.00
      Divide the remainder by the
      number of remaining months in
      the fiscal year = $360.00 - 7
      = Weighted per diem rate = $ 51.43

   b. Example 2. Provider's interim rate has been in effect for six (6) months. Provider's weighted rate will be in effect for six (6) months:

      Allowable per diem rate
      for the year $ 50.00
      Interim rate paid $ 48.00
      Allowable per diem rate
      multiplied by 12 = $50.00 x 12 $600.00
      Deduct interim per diem rate
      multiplied by number of months
      paid = $48.00 x 6 = $288.00
      Remainder = $312.00
      Divide the remainder by the number
      of remaining months in the fiscal
      year = $312.00 - 6 = Weighted per
      diem rate = $ 52.00

   c. Unapproved Beds. Capital expenditures must be approved under the State Certificate of Need Program.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended March 15, 1983; May 9, 1984, and September 8, 1984. Emergency rule effective December 1, 1986. A permanent rule incorporating the provisions of this Emergency Rule was not adopted and therefore the original wording in paragraph 5 was reinstated upon expiration of the Emergency Rule. Amended September 9, 1987; March 12, 1988; and June 14, 1989. Emergency rule effective June 20, 1989. Amended September 13, 1989. Emergency rule effective January 17, 1990. Amended April 17, 1990 and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.06. Reimbursement Methodology.

1. All nursing facilities will be grouped into three (3) functional categories:

    a. Nursing Facility (NF)

    b. Nursing Facility/Institution for Mental Disease (NF/IMD)

    c. Nursing Facility/Institution for the Developmentally Disabled (NF/IDD)

2. The following methodology shall apply: Cost reports, as submitted, will be desk audited for any unallowable costs, and those costs will be removed from the subsequent computations. The providers' reported allowable costs will be used as the basis for calculating the new per diem rates. All similar allowable costs will be categorized into one of the four (4) groups: operating costs, direct patient care cost, indirect patient care cost, and property cost. NF/IMD and NF/IDD facilities will be exempt from all ceilings. The following methodology will be used for determining the per diem rates for approved beds.

3. Ceilings are to be limited to the previous year's ceiling increased by no more than four (4) percentage points over the DRI inflation index. Should the computed ceiling exceed that index, the lower amount will be used. For example:

    FY 96 ceiling =$50.00
    DRI index = 3.5%
    Limit =$50.00+(.035+.04)($50)
    $50.00+$3.75=$53.75
    Computed Ceiling =$54.50
    FY 97 Ceiling =$53.75

    a. Operating Cost Center. The allowable management and administrative costs (See Rule 560-X-22-.10), after inflation index is applied, for each facility will be divided by reported patient days. All nursing facilities will be grouped by the number of beds in the facility and the operating costs for each facility will be separated into two bed size groupings, 75 beds or less and 76 beds and over. Each grouping will be arrayed by the cost per patient day and the median plus 5% will be determined for each grouping and that will be the ceiling. This ceiling, or actual cost, whichever is less will be used for each provider's rate computation.

    b. Direct Patient Care Cost Center. Direct care costs, after inflation index is applied, consisting of nursing services, raw foods, medical director, nursing consultant, pharmacy consultant, and dental consultant for each facility will be divided by reported patient days. These costs per patient day will be arrayed and the ceiling for the direct patient care cost center will be the median cost per patient day plus 10%. The provider's actual allowable reported cost per patient day plus 10% not to exceed the established ceiling plus 10%, whichever is less will be used for each provider's rate computation.

    c. Indirect Patient Care Cost Center. Costs for plant operations, dietary (minus raw foods), laundry (less costs associated with patient personal laundry), activities, social services, housekeeping, beauty and barber (if provided free of charge by the facility), dietary consultant, social services consultant, and other allowable costs, after inflation index is applied, will be divided by reported patient days. These costs per patient day will be arrayed and a median cost per patient day will be determined. The ceiling for indirect patient care costs is the median cost per patient day plus 10%. The providers actual allowable reported cost per patient day plus 50% of the difference between actual allowable cost and the established ceiling, up to the ceiling amount, will be used for each provider's rate computation.

d. Property Cost Center. In lieu of depreciation expense, lease expense, and a return on equity, a Fair Rental return (See Rule 560-X-22-.14 for detailed explanation) will be computed for each provider using the following procedure:

   1. A current asset value per bed will be established. This current asset value will initially be set using the standard value of $25,000 per bed and reducing by 1% for each year of age, or fraction of 1% for partial years, not to exceed a 50% reduction or a minimum value of $12,500 which will be applied as a floor. In order to keep pace with rising construction costs, a rebasing system will be established. The mechanism for rebasing will be to index the current asset values each year. The Marshall-Swift Evaluation Service will be used for adjusting to inflation.
   2. A Gross Rental Factor of 2.5% will be multiplied by the current asset value of the facility to determine the rental value of the facility.
   3. The "Rate of Return on Current Asset Values" will be computed in two parts. First, the current asset value of the facility, less the balance due on allowable notes incurred to purchase all land, buildings, and equipment, will be multiplied by the "current yield on 30 year U. S. Treasury Bonds" as of June 30th each year. Second, the current asset value will be multiplied by a "risk premium of 1.5% for ownership". The two products will then be added together.
   4. Interest expense related to allowable notes incurred to purchase land, buildings, and equipment will be determined.
   5. Property taxes and property insurance costs will be determined.
   6. The rental value, rate of return, allowable interest, property taxes, and property insurance costs, less laundry adjustment from Fair Rental, will be totaled and that total will be divided by the facility's reported patient days to determine the facility Fair Rental payment which will be used to compute the facility's rate.

e. After the Operating costs, direct patient care costs, and indirect patient care costs have been added together the Allowable Property Costs are added. The resulting costs is the rate per patient day for the cost report year.

f. Example:

   1. Operating Costs (Actual allowable reported costs per patient day up to the ceiling).
   2. Direct Patient Care Costs (Actual allowable reported cost per patient day plus 10% not to exceed the established ceiling plus 10%).
   3. Indirect Patient Care Costs (Actual allowable reported cost per patient day plus 50% of the difference between the reported cost and the ceiling up to the ceiling amount).
   4. Total of Items 1, 2, and 3.
   5. Allowable Property Costs.
   6. Laundry fee-for-service.
   7. Total of Items 4, 5, and 6.

g. NF/IDD facilities will not be subject to the above outlined ceilings, however, their rates will be computed in a like manner.

h. NF/IMD facilities and any other facility owned and operated by the State of Alabama will have their rates computed in the above manner, but will not be eligible for incentive payments in the direct care and indirect care areas, nor will they receive a Fair Rental payment. Instead, their rates will be determined using actual cost with no ceiling limitations and a usage allowance for property costs (2% for buildings and 6 and 2/3% for equipment).

4. Ceilings Not Subject to Adjustments. Once the ceiling has been established for a fiscal year, it will be final and not subject to revision or adjustment during that year. However, at the discretion of the Agency, it may be changed upon discovery of material error. Since the ceiling rate is based on information provided in the cost reports, it is to the benefit of each provider to insure that their information is correct and accurate. If obvious errors are detected during the desk audit process, providers will be given an opportunity to submit corrected data.

5. After the rates have been set, each provider will be notified of its rate. If the provider has questions regarding any disallowances made during the rate setting process, they may request further information in writing. Only those requests submitted in writing will be honored.

6. During the fiscal year, the Commissioner of Medicaid will consider extraordinary expenditures which are not reasonably foreseeable and are totally beyond the control of the provider. (Example: Additional personnel or equipment mandated by federal or state governmental agencies.) Such expenditures do not include those, which can be reasonably anticipated in connection with inflation, such as employee compensation increases and employee benefit increases. Requests to Medicaid for consideration must be fully substantiated, to include the reason for the request, total computed cost, effective date and other supporting data, as pertinent.

    a. Costs (as referenced in (5) above) which are approved and added to a projected rate during the period January 1 - June 30 are subject to retroactive settlement upon submission of the next cost report. Costs which are approved and added to a rate during the rate period July 1 - December 30 shall be settled through the next rate weighting cycle (January 1 - June 30).

7. The monthly rate is computed by multiplying the per diem rate by 30.42 days. This rate is valid for patients in the nursing facility for the full month. For partial monthly coverage, the per diem rate is multiplied times the number of days.

8. Dollar values are rounded.

9. Effective July 1, 1989, the reasonable allowable costs of compliance with the provisions of Section 4211 OBRA 87 as incurred by nursing facilities for nurse aide competency evaluation and training is recognized for purposes of reimbursement. Reimbursement for these costs will be as follows:

    a. For those employees hired prior to July 1, 1989, nursing facilities will be reimbursed the Medicaid share (based on percentage of occupancy) of costs associated with the original competency evaluation as incurred and documented. These costs will be reimbursed as a pass through item outside the per diem rate, not subject to the 60th percentile upper limit.

    b. For the period July 1, 1989 through December 31, 1989, nursing facilities will budget the allowable costs of nurse aide training and competency evaluation. The resulting amount per day, for these costs only, will be added to existing per diem rates outside the 60th percentile limitation. These budgeted costs will be subject to retroactive adjustment when the actual cost is verified.

    c. Subsequent reimbursement of nurse aide competency evaluation and training expenses will be paid outside of the normal per diem system. Nurse aide training expenses allowed to be paid outside the normal per diem system are costs of the test, any charge for training by other than the facility, necessary supplies, and cost of transportation of the aide to the training or testing site. These expenses should be reported in the unallowable section of the cost report, on a separate line, and identified as nurse aide training expenses. An attachment to the cost report is required itemizing expenses. If equipment costs are included, the normal capitalization policy will apply. These expenses will be extracted from the cost reports and paid at a later date as a separate payment. Under the current rules, these procedures will continue into future years.

d. Equipment used in nurse aide competency evaluation and training. Reimbursement for equipment (i.e., ProCare) will be reimbursed by one of the following methods:

1. Will be recognized as medical specialized equipment and capitalized and depreciated over a useful life of three (3) years, or
2. A rate of $30.00 will be paid for each nurse aide that is trained and passes the competency test.

Because nurse aide training is considered an Administrative Cost by HCFA and has a federal match of 50%, these costs cannot go through the cost report. These costs must be reported in the "unallowable" section of the cost report and will be paid as outlined in (c) above.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended July 9, 1984; August 11, 1986; March 12, 1988; and July 13, 1989. Emergency rule effective January 22, 1990. Amended April 17, 1990. Emergency rule effective May 1, 1990. Amended August 14, 1990 and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991. Amended August 12, 1992. This amendment effective January 12, 1998.

Rule No. 560-X-22-.07. Medicaid Inflation Index.

1. The Medicaid Inflation Index will be used in lieu of budgeting to adjust certain actual allowable costs from one reporting period for the purpose of computing the per diem rate payable for a subsequent reporting period and for such other adjustments as may be specified in this Chapter.

2. The Medicaid Inflation Index shall be based upon the economic indicators as published by Data Resources, Inc. (DRI) for the Department of Health and Human Services. The indicators shall be the Market Basket Index of Operating Costs - Skilled Nursing Facility, which are published quarterly, whereas the Medicaid fiscal year for cost reporting and rate setting purposes ends on June 30th. Therefore, the Medicaid Inflation Index for a rate period will be the DRI Index for the twelve-month period ending on the calendar quarter for which the index has been published or made available at October 1st of each year.

3. The Medicaid Inflation Index will be established each October 1st for the current fiscal year based upon the information then available to Medicaid and will not be adjusted again until the next following October 1st, regardless of any later release of revised or additional information relevant to the determination of the index.

4. Interim Inflation Factor. The interim rate shall be the lower of the latest allowable computed rate (560-X-22-.05(1)(b)7) or the ceiling rate per day. The applicable allowable rate per day shall be trended by the Alabama Medicaid trend factor. The trend factor shall be the National Forecast-Nursing Home Market Basket for the following fiscal year as published by Data Resources, Inc. This forecast is published quarterly; therefore the latest forecast available at June 1st each year shall be used.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.200 - .272. Rule effective October 1, 1982. Amended September 8, 1984 and July 9, 1985. Amended October 1, 1990. Emergency rule effective October 1, 1990. Effective date of this amendment December 14, 1990. This amendment effective January 12, 1998.

Rule No. 560-X-22-.08. Patient Days.

1. A patient day is incurred when any one of the following conditions have been met:

    a. Care is rendered to a patient in the facility. This results when a patient is rendered services between the census taking hour (12:00 midnight) on two (2) successive days. The following procedure illustrates the proper method of determining the number of patient days resulting from care rendered to patients in the facility, using the midnight census method:

        1. Number of patients in the facility at midnight
        2. Add/subtract patients admitted/discharged (including deaths) prior to midnight of the following day (Exception - a patient admitted and discharged on the same day counts as a patient day.) The provider may bill for the date of admission, but not for the day of discharge.

    b. When pre-admission payments are received to insure a bed is kept open for a particular patient. The rationale for including these payments lies in the fact that this bed is not available for occupancy by another patient. Since the facility is receiving payment for a bed which is, in effect, unavailable to any other patient, it should be included in patient day totals.

    c. When a patient is out of the facility, regardless of the reason, and the nursing facility is receiving payment for the bed, this day is counted in the same manner as pre-admission payments as stated above. If the nursing facility is not receiving payment for the bed, it will not be counted as a patient day.

    d. Medicaid payment will only be made for therapeutic visits not to exceed three (3) days per visit and six (6) such visits per patient during any twelve-month period. Visits are limited to two (2) per calendar quarter to home, relatives, and friends. Limitations do not apply to patients in institutions for the mentally retarded or persons with related conditions. The long term care facility must ensure that each therapeutically indicated visit by a patient is authorized and certified as necessary by a physician. (See Schedule 8A at end of chapter.)

2. Minimum records required to be kept at the facility are:

    a. Midnight census by patient name at least one time per calendar month. More frequent census taking is recommended.

    b. Ledger of all admissions and discharges/deaths.

    c. Complete therapeutic leave records.

    d. A monthly analysis sheet which summarizes all admissions and discharges, paid hold bed days, and therapeutic leave days. (Schedule 8A at Rule No. 560-X-22-.08 is the recommended analysis sheet, however, providers may utilize any form of their own design if it provides the same information.)

3. In the event that payment for a pre-admission day is not received and the charges are subsequently written off as uncollectable, the facility will not count those days as patient days. The facility must keep a separate ledger to indicate days in this category. The ledger must indicate the following:

    a. Patient name

    b. Dates of pre-admission days charged

    c. Dates of preadmission days written off as uncollectable

    d. Reason for uncollectability

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended May 15, 1983 and August 10, 1983. Effective date of this amendment October 1, 1990.

Rule No. 560-X-22-.09. Staffing.

1. Providers are expected to staff Nursing Care functions in accordance with state licensure requirements.

2. Staffing of each functional area within each facility will be reviewed by Medicaid for reasonableness.

3. An adjustment will be made to decrease allowable costs for facilities which are deemed to be overstaffed in any particular functional area.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Amended October 1, 1990.

Rule No. 560-X-22-.10. Management and Administrative Costs.

1. Costs of a management or administrative nature, including but not limited to those costs outlined in Rule No. 560-X-22-.10(3), will be reported as such on the Medicaid Cost Report. Salaries of administrative personnel which would duplicate employee salary expenses in other cost centers cannot be allocated to such non-administrative cost centers.

2. Customarily, owner compensation results from a distribution of the profits. However, when the owner provides a necessary service to the facility, he/she can justifiably be compensated at a reasonable rate, then that owner compensation is an allowed cost. "Reasonable compensation" must meet the criteria of being paid to an employee who performs a necessary function in a facility and must be in an amount which would ordinarily be paid for comparable services in a comparable facility. To be "necessary," a function must be one that if that employee were not performing it, another would have to be employed to do so, and additionally, the function must be directly related to providing nursing facility services.

3. Examples of Allowable Management and Administrative Costs include, but are not limited to:

    a. Salaries and Bonuses

        1. Administrator
        2. Assistant Administrator
        3. Accountant
        4. Bookkeeper
        5. Computer Operator
        6. Medical Records Clerk
        7. Personnel Officer
        8. Secretary
        9. Typist
        10. Clerks
        11. Receptionist
        12. Telephone/Operator/Switchboard

    b. Legal Fees (Legal fees related to patient care, except those specified in Rule No. 560-X-22-.22)

c. Consultants - Medical Records

d. Outside Accounting and Auditing

   1. Routine Bookkeeping
   2. Preparation of costs reports
   3. Auditing and related statement

e. Data Processing

   1. Owned
   2. Rented
   3. Outside purchased service

f. Professional Development

g. Supplies

   1. General administration
   2. Medical records

h. Telephone Expense - Subject to limitations in Rule No. 560-X-22-.22(3)(u)

i. License

   1. Business
   2. Administrator's
   3. Direct care professional staff (to be reported in the appropriate functional cost center)
   4. Professional staff if their employment negates the need for contracting with a consultant (to be reported in the appropriate functional cost center)

j. Insurance

   1. Professional Malpractice and related deductibles

k. Employee Benefits - Administrative Employees

   1. Group Life
   2. Group Health
   3. FICA
   4. SUI
   5. FUTA
   6. Deferred Compensation Plans, Pension and Profit Sharing, approved by IRS
   7. Workman's Compensation Insurance

l. Advertising

   1. Telephone, local
   2. Employment ads
   3. Public Relations ads (not in excess of $100.00 per fiscal year)

m. Postage

n. Management Home Office Cost (chain operation)

   1. Management and administrative salaries and benefits. (To be reported on lines D5-1 and D5-2 as appropriate)

2. All building costs, including but not limited to: (To be reported on line D5-17)
    a. Insurance
    b. Rent
    c. Lease
    d. Utilities
    e. Depreciation
    f. Interest

o. Interest Expense on working capital loans, subject to limitations contained in Rules No. 560-X-.11 and .22.

p. Management fees not exceeding the cost of the provider of the services and not excluded under Rule No. 560-X-22-.22(3)(a).

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Effective date of amendment May 15, 1983. This amendment will apply for cost reports for the fiscal year ending 6-30-83. Amended October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.11. Interest Expense.

1. Necessary and reasonable interest expense is an allowable cost. In order to be considered necessary, the interest must be incurred on a loan made to satisfy a financial need directly related to patient care. Loans which result in excess funds or which are not related to patient care are not considered necessary. In order to be considered reasonable, the interest rate cannot be in excess of that which a prudent borrower would agree to pay, and the lender must not be related to the borrower. The provisions of HIM-15 shall be applicable in determining whether a loan is between related parties. Interest paid by the provider to owners, partners, stockholders, or other persons related to the provider is not an allowable cost.

    a. Bond discounts or premiums and loan costs will be amortized over the life of the bond issue using the straight line method and such amortization will be treated as interest. Amortization will be added to interest expense in the case of discounts and loan costs and deducted from interest expense in the case of premiums.

        1. For purposes of Medicaid reimbursement, the term "discount," as applied to debt, means any front-end payment to a lender or any reduction of principal received from a lender as a condition of obtaining the loan. It encompasses the generic terms of discount, loan points, and commitment fees.
        2. Allowable loan costs will be limited to expenditures required by the lender, such as title searches, recording fees, etc. However; fees for project development, feasibility studies, or financial advisors will not be allowed.
        3. Only the portion of the discount or premium and loan cost that is related to the allowable basis of the facility, as determined by Medicaid, can be amortized and claimed for reimbursement. Allowable portion will be computed as follows:

            Current Asset Value X Current Unamortized
            Disc./Premium = Allowable Discount/Premium
            Balance Due on Note
            Should the result be more than 100%, the full discount/premium will be allowed.
        4. Interest expense will be allowed for debt, discount and/or premium, and loan costs that are related to the allowable Medicaid basis. The computation of the allowed loan cost will be the same as for allowable discounts as described in 560-X-22-.11(2)(c).

5. Example:

Outstanding Debt at 9/1/91	$2,500,000
Remaining Term of Debt	25 years
Interest Rate	10%
Current Asset Value at 9/1/91	1,826,000
Discount	125,000
Escrows	150,000
Loan Costs	(Subject to the 120,000 provisions of 560-X-22-.11(2)(b)(2) 560-X-22-.22(3)(e)&(f))

6. Allowable Interest Computation:

Allowable Discount
1,826,000 X 125,000 = $91,300
2,500,000
Allowable Loan Cost
1,826,000 X 120,000 = $87,648
2,500,000

Medicaid Basis	$1,826,000
Discount	91,300
Loan Cost	87,648
Total Int. Basis	$2,004,948

Interest & Debt Allowable
2,004,948 = 80.2% of Annual Interest Incurred
2,500,000 on Notes Outstanding

First year Interest	$250,000
Medicaid Allowable	.802
Allowable Interest	$200,500

Allowable Amortization:

Discount	91,300	25	3,652
Loan Cost	87,648	25	3,506

Total Reimbursable Int.
and Amortization $207,658

Once percentages of allowability have been established, they will remain in effect until there is a change in owner ship. Sale of stock or corporate reor ganization does not constitute a change of ownership. A revelation of assets will be permitted where the purchase of stock of a corporate provider is fol- lowed within three (3) months by the liquidation of the provider. Any revalation of the assets of a provider as the result of such liquidation shall be subject to the same prior approval and basis limitations as though an outright sale of the assets has been made.

2. Interest incurred during the period of construction on funds borrowed to construct, improve, or enlarge existing facilities must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility, improvement, or renovation is put into use for patient care. Where a bond issue is involved, any bond discount and expense, or bond premium amortized during the period of construction must be capitalized and included in the cost of the facility constructed.

a. If a debt which was incurred to finance the construction, expansion, renovation, or acquisition of a nursing facility is refinanced, allowable interest on the new loan will be limited to that portion of the loan that represents the unpaid allowable balance of the previous loan subject to the methodology outlined in (2)(e) above. Interest expense, plus applicable amortization cannot exceed the amount that would have been allowable under the terms of the previous loan agreement.

b. When a loan is refinanced, any allowable unamortized discounts/premiums and loan costs will be written off the provider's books. Such written-off amounts will be treated as a prepayment penalty subject to the provisions of paragraph (5) below.

3. If the provider incurs a prepayment penalty on the early extinguishment of an interest bearing debt, such penalty may be an allowable cost subject to the following guidelines:

   a. If the allowable interest incurred, plus the penalty (prorated for the allowable portion of the debt) does not exceed the interest that would have been allowed had the debt not been paid off, then all of the interest and penalty can be claimed.

   b. If the allowable interest incurred, plus the penalty (prorated for the allowable portion of the debt) exceeds the interest that would have been allowed had the debt not been paid off, claim may be made for the amount that would have been allowed had the debt not been paid off. The excess penalty may then be carried forward and claimed in subsequent years in a manner such that actual interest incurred, plus penalty does not exceed the interest that would have been allowable under the previous financing agreement.

   c. In no instance will the provision of (5)(b) be carried forward in excess of five years.

4. The payment of a lease payment to a medical clinic board, under a lease agreement containing a purchase option at a price below the fair market value, is generally not allowable as a true lease payment. It will generally be treated as a lease purchase which must be capitalized. Payments of bond interest will be subject to the above outlined provisions.

5. Financing that provides for no scheduled periodic reduction of the principle amount of the loan will not be recognized by Medicaid. The provider will, instead, submit to the Chief Auditor, Provider Audit, such information as necessary in order to generate an appropriate amortization schedule for the loan amount. This schedule will be used to compute allowable interest as outlined in paragraph (2)(e) above.

   a. Interest must be reported on the cost report in two distinct areas: working capital interest in the Administrative cost center (subject to the operating cost center ceiling), and other interest reported in the Fixed Cost center.

   b. Working capital interest is limited to short term loans (normal term of less than six months) taken out to meet immediate needs of daily operations. To be allowable, there must be a genuine effort by the provider to repay these notes. If no evidence of repayment is apparent and these notes are merely renewed throughout the year, Medicaid will not consider these to be bona fide working capital notes; and the interest incurred on them will not be allowable if no justification can be made for nonpayment of the note. Allowable interest on working capital notes will be limited to no more than 90 days interest on two months of the provider's average allowable cost net of property cost. The rate used for this computation will be the average rate charged by the lender during the year, as reported on schedule L of the cost report.

6. Only interest expenses incurred and payable to a lender, as evidenced by a signed loan agreement, will be considered for reimbursement. Additional interest expense created by restatement of loan agreements, under generally accepted accounting principles, or created by imputing a different rate from the one stated in the loan agreement, will not be allowable. For example, an imputed interest expense resulting from the application of Accounting Principles Board Opinion No. 16 or No. 21, or any similar accounting principle, and any other imputed interest expense shall not be recognized as a valid interest cost for purposes of computing the provider's allowable Medicaid reimbursement.

7. If financing obtained to purchase a facility is a combination of assumed debt and new financing, allowable interest will be prorated among all debt interest, i.e., if the total debt is determined to be 90% allowable, then 90% of the total interest will be allowable.

8. If loans are made by the facility to related parties during the reporting period and working capital loans are taken out or remain outstanding during any period in which the related party loans are outstanding, then the interest on the portion of the principal amount of such working capital loans equal to the principal amount of such related party loans is not reimbursable.

9. Providers are required to maintain adequate records to allow for audit verification by Medicaid auditors. Minimum records required are:

    a. Loan/Mortgage Agreements which state the purpose of loan

    b. Repayment Schedule/Amortization Schedule

    c. If a loan is refinanced, the above records must also be kept for the prior loan

Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended March 11, 1986 and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.12. Laundry Expense.

1. Allowable costs will be limited to the laundry costs which are ordinary and necessary to the operation of a nursing facility and will not include costs associated with the personal laundry of patients.

2. Examples of such costs include, but are not limited to, the following:

    a. Salaries and employee benefits attributable to laundry personnel

    b. Supplies and materials used in providing laundry services

    c. One and one half percent (1.5%) of Fair Rental to be applied to laundry

    d. Costs directly attributable to the delivery of laundry

    e. Charges by an outside laundry

3. Allowable salaries and benefits will include all personnel directly involved in performing this service. Delivery costs will be subject to the limitation in Rule No. 560-X-22-.13, "Travel Expense".

4. The total cost of handling the personal laundry of patients must be deducted from actual laundry costs. If this cost cannot be separated from other laundry costs, two (2) one-week laundry studies based on weight must be conducted by the facility at six (6) month intervals. The laundry costs will then be reduced by the personal laundry proportion as determined by the studies.

5. Medicaid will reimburse providers a fixed fee of $1.25 per patient day for providing patient personal laundry service. All providers must offer this service to Medicaid patients. If a patient declines to use the service, a signed statement from the patient and/or his sponsor attesting to this fact must be on file.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended July 8, 1984 and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.13. Travel Expense.

1. Travel that is necessary and that is directly related to the operation of the nursing facility claiming reimbursement for the expense will be an allowable cost for reimbursement purposes pursuant to the following specific provisions.

    a. Automobile

        1. Since the form of vehicle ownership, the type, and the number of vehicles utilized will vary depending on a facility's specific needs, reimbursement will be based on a standard mileage rate and will be limited to mileage which is documented by log entries prepared in accordance with either of the attached sample logs. (See Schedules 13A and 13B found in this rule.) Reimbursement to employees for the use of their personal vehicles will be limited to the lesser of the actual reimbursement to the employee or the standard mileage rate per section three (3) of this rule. All log entries must be made at the time of travel, and log entries will be subject to verification during audit. Failure to timely and accurately account for travel mileage will result in a disallowance of this cost.
        2. Commuting mileage between the commuter's residence and the nursing facility is not allowable mileage for reimbursement purposes. (See Schedule 13A at end of chapter.)
        3. The standard mileage rate is as follows: The IRS mileage rates in effect on January 1 of the calendar year in which the cost report is filed (January 1, 1990 for cost reports filed as of June 30, 1990). These rates will be applied on a per provider basis regardless of the number or type of vehicles used. (See Schedule 13B at end of chapter.) In addition to the mileage rate listed above, up to $1,000.00 in actual operating costs (i.e., gas, oil, upkeep) of one automobile per nursing facility may be reimbursable. There will be no additional reimbursement in those instances in which the facility auto is used for commuting purposes of the administrator or non-patient care related activities. To qualify for this additional allowance, the facility must own or lease a vehicle, the vehicle must be used only for purposes of patient care, and actual operating expenses must exceed the computed mileage allowances. In no instance will the facility be allowed to claim more than the standard allowance plus the $1,000 (if computed allowance is less than operating cost) or actual operating costs, whichever is less.

Examples:

Facility Owns Vehicle	Medicaid Mileage Allowance	Actual Operating Expense	Allowance
Yes	$ 2,325	$ 2,115	$ 2,325
Yes	2,325	4,125	3,325
Yes	2,325	2,765	2,765

If the facility does not own a vehicle, reimbursement will be limited to actual payments to employees for use of their personal automobiles for documented facility business, provided that such reimbursements do not exceed the allowable rates. (IRS guideline)

4. No additional reimbursement in excess of $1,000.00 will be recognized for any other automotive-related cost. Those additional costs which will not be recognized include, but are not limited to:

(i) Depreciation
(ii) Interest on automotive loans
(iii) Lease/rental expense
(iv) Taxes, tags and insurance
(v) Return on equity

5. No reimbursement will be made or considered for unusual or impractical vehicles, which include but are not limited to aircraft, motorcycles, farm equipment and other vehicles not necessary to the efficient operation of the facility.

(b) Other travel

1. Costs of travel to out-of-state conventions or association meetings will be limited to those reasonable costs incurred by a facility for two trips during each fiscal year. If the facility bears the expenses of two persons attending the same convention or association meeting, such attendance will be counted as two trips. Reimbursement will be considered only for bona fide employees of the facility whose attendance will benefit the operation of the facility. Expenses related to travel expenses of employee spouses will not be eligible for reimbursement unless the spouse is a bona fide employee of the facility and has a legitimate reason, related to patient care, for such attendance. Since only patient care related travel is allowable, evidence must be on file to verify that the travel was patient care related. Such evidence may be: (a) seminar registration receipts, (b) continuing education certificates, (c) similar documentation. If verification cannot be made, reimbursement will not be allowed. Out-of-State travel living expenses will be limited to $125.00 per day for the length of the functions attended. Per diem for the date of return will be limited to $50.00 because lodging is not required.

2. Transportation expenses in or out-of-state will be limited to the ordinary and necessary costs of transportation, food, lodging, and required registration fees.

3. Whenever out-of-state travel could be accomplished at a lower cost by utilizing air travel, reimbursement will be limited to the costs which would have been incurred if such air travel had been utilized and the costs normally incident to such air travel (meals, lodging, etc.).

4. No travel expenses of a non-business nature will be reimbursed.

5. Travel which requires an overnight stay must be documented by a travel voucher which includes the following:

(i) Date
(ii) Name of person
(iii) Destination
(iv) Business purpose
(v) Actual cost of meals and lodging (lodging must be supported by invoices, meal receipts must indicate number of meals served for any meal in excess of $20.00).
(vi) Air, rail and bus fares (supported by an invoice)

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.200 - .272 et seq. Rule effective October 1, 1982. Amended May 15, 1983; July 9, 1984; September 8, 1984, February 9, 1989, and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.14. Property Costs.

(1) In order for any property costs to be reimbursed through the Medicaid program, capital expenditures must be approved under applicable Certificate of Need regulations by appropriate state and/or federal agencies. Capital expenditures, as used in this Chapter, means new construction, major renovations, bed additions, or replacement beds in a nursing facility.

(2) Effective September 1, 1991, a Fair Rental System will be used to reimburse property costs. The Fair Rental System reduces the wide disparity in the cost of capital payments for basically the same service and makes the cost of capital payment fairer to all participants in the program. The Fair Rental System is a rate of return on current asset values and will be used in lieu of depreciation and/or lease payments on land, buildings, and major movable equipment normally used in providing patient care.

(3) The following factors will be used to arrive at a "Rate of Return on Current Asset Values":

The current yield on 30 year U. S. Treasury Bonds *	
A risk premium for ownership	1.5%
A Gross Rental Factor	2.5%

* Latest yield as of June 30

(4) The amount of $25,000 per bed will be used to reflect the standard value per bed as of September 1, 1991. This standard value reflects the allowable cost of a newly constructed facility to include land, buildings, and all major movable equipment needed to place the facility in operation.

(5) Current asset values are found by taking the standard value of $25,000 per bed and reducing that amount by 1% for each year, or fraction thereof for partial years, of age for a maximum of 50 years. A minimum value of $12,500 per bed will be applied as a floor. Once these values have been set, they will be subject to rebasing yearly using the Marshall-Swift Valuation Service data. They will not be subject to further reduction for age.

(6) Net asset values are found by taking current asset values and reducing them by outstanding allowable debt for land, building, and equipment. Allowable debt is determined by subtracting any escrow funds related to the debt from the current balance due. The remainder will be considered allowable debt up to the amount of the facility's current asset value.

(7) The following property costs will normally not be reimbursed under this Fair Rental System: (a) depreciation and (b) rent for land, buildings, and equipment.

(8) Sale of Existing Facilities: Effective for sales closed on or after September 1, 1991, the allowable basis to the purchaser of an existing facility in the Medicaid Program will be the Current Asset Value of the previous owner.

(9) New Facilities. In the year in which a new facility is opened, the most recently computed standard asset value will be used to determine fair rental values.

(10) Renovations. If a provider makes a major improvement or renovation to the facility, the current asset value of the facility may be adjusted by Medicaid. Renovations for the purpose of this chapter shall be defined as real and fixed property changes to a nursing facility. The American Hospital Association publication, "Estimated Useful Lives of Depreciable Hospital Assets," tables 2, 3, and 4 will be used to determine real and fixed property affected by this rule. Facilities wishing to make renovations must submit the renovation project to Medicaid for approval. Facilities submitting a renovation project must fully define the project and include all anticipated and projected costs of the project. At the time of

completion of the renovation project, the cost projections should not exceed the original costs submitted plus fifteen percent (15%). Medicaid will approve or disapprove the renovation project within thirty (30) days of receipt. Renovation projects receiving disapproval will be given the reason for disapproval. Facilities receiving a disapproval will be given an opportunity for an appeal in accordance with Rule No. 560-X-22-.27. Renovation projects approved will be issued a certificate of approval. The certificate of approval will be valid for a period of twelve (12) months from the date of approval. If a facility, due to unexpected circumstances, is unable to complete the renovation project within the original twelve (12) months, the Medicaid Agency may grant an extension of no more than twelve (12) additional months. Medicaid will adjust the current asset value and set an interim rate for the facility during the month in which the renovation project is complete and all final invoices are submitted to Medicaid. Improvements and/or renovations costing less than five percent (5%) of the current asset value at the time of the renovation and/or improvement will normally not be considered for adjustment, as the provider's return from the Fair Rental payment has been designed to cover them. Any improvement and/or renovation with a cost in excess of five percent (5%) of the current asset value at the time of such improvement and/or renovation must be submitted to Medicaid, for review and adjustment to the current asset value, as appropriate. If a provider feels that a renovation or improvement not meeting the above requirements should be considered for an adjustment to the current asset value and interest base, as appropriate, they may request an exception to policy from Medicaid. Such consideration for exception will be limited to unexpected or unanticipated events, such as acts of nature or latent damages to the facility.

(11) Rebasing. The current asset value of all facilities participating in the Alabama Medicaid program will be rebased each year as of July 1. Rebasing will consist of adjusting the current asset value by indexing to reflect changes in construction cost. The Marshall-Swift Evaluation Service will be used to compute the change as of June 30 of each year. The index adjustment will be limited to no more than 3% each year.

(12) Depreciation. Depreciation expense on buildings, fixed equipment, and major movable equipment normally used in providing patient care and operation of a nursing facility will not be an allowable expense. The American Hospital Association publication, "Estimated Useful Lives of Depreciable Hospital Assets," will be used to determine the assets affected by this rule. Specialized equipment purchased by a facility for use in the treatment of heavy care patients will be depreciated over its useful life, and such depreciation expense will be an allowable cost for reimbursement. This equipment will be limited to those items listed in paragraph 19 below and the useful life indicated.

(13) Equipment Rental. Rental expense related to equipment normally used in providing patient care or operation of a nursing facility is not an allowable expense. Rental expense for specialized equipment acquired to treat heavy care patients will be allowed for reimbursement. This equipment will be limited to those items listed in paragraph 19 below.

(14) Insurance on Building and Contents. The reasonable costs of insurance on buildings and their contents used in the rendition of covered services purchased from a commercial carrier or a limited purpose insurer subject to the provisions of HIM-15, Section 2162(2) will be considered as allowable costs.

(15) Property Taxes. Ad Valorem and personal property taxes on property used in the rendition of covered services are allowable under this section. Fines, penalties, or interest related to those taxes are not allowable.

(16) Nursing Facility Privilege Tax. Taxes, interest and penalties established by Section 40-26B-20, et seq., Code of Alabama (1975) on nursing facility beds are unallowable through December 31, 1992. Beginning January 1, 1993, such taxes are allowable. Interest and penalties related to these taxes are not allowable.

(17) Life and Rental Insurance. Premium payments for life insurance required by a lender or otherwise required pursuant to a financing arrangement will not be an allowable cost. Loss of rental insurance will also be considered an unallowable cost.

(18) Minor Equipment. Minor equipment purchases may be expensed and claimed for reimbursement. Minor equipment, for the purposes of reimbursement is any equipment that has a unit cost of $300 or less (beds, at any cost, are not to be reimbursed as minor equipment). Minor equipment expenses are to be included in the cost area in which the equipment is normally used. Group purchases of minor equipment, either in a single purchase or through periodic purchases throughout the reporting year, with an aggregate cost of $5,000 or more, must be capitalized and depreciated over the useful life of the assets. The depreciation expense must go on Schedule D, line 55-4 of the cost report.

(19) Expense related to the purchase and/or rental of the below listed items may be claimed by the provider in addition to the prevailing fair rental reimbursement. The provider shall maintain adequate records to substantiate any rentals, depreciation and interest expenses.

	Item	Life
1.	Feeding pump	10 years
2.	IPPB machine	5 years
3.	Ventilator	10 years
4.	Apnea monitor	5 years
5.	Oxygen Concentrator 3 Lpm	5 years
6.	Oxygen Concentrator 5 Lpm	5 years
7.	Oxygen nubulizer + heater	10 years
8.	Clinitron	15 years
9.	Aerosol machine without compressor	10 years
10.	Aerosol machine with compressor	10 years
11.	I vac pump	10 years
12.	ProCare System	3 years

This list is not intended to be all-inclusive. Additions will be made on an as needed basis. Requests for additions must be submitted to Chief Auditor, Provider Audit for approval. The amount of reimbursement will be determined by dividing the cost of rentals, depreciation, and interest incurred for equipment used by Medicaid recipients by the reported Medicaid days. The resulting per diem will be added to the provider's property cost per diem.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.200 - .272. Rule effective October 1, 1982. Amended May 15, 1983; July 9, 1984, and December 6, 1984. Emergency rule effective November 20, 1984. Amended February 8, 1985; June 10, 1987; November 17, 1987, March 12, 1988, and May 12, 1989. Emergency rule effective May 1, 1990. Amended August 14, 1990 and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991. Amended August 12, 1992. Emergency rule effective January 1, 1993. Amended April 15, 1993. Emergency rule effective February 9, 1993. Emergency rule effective July 1, 1993. Emergency rule effective October 28, 1993 through December 13, 1993. Amended December 14, 1993. This amendment effective December 12, 1995. Amended January 12, 1998. Emergency rule effective February 1, 1998. This amendment effective June 1, 1998.

Rule No. 560-X-22-.15. New Facility, Change in Ownership, or Change in Category of Care.

(1) A provider who constructs, leases, or purchases a facility, or has a change in category of care, can request reimbursement based on an operating budget, subject to the ceiling established under Rule Number 5 of this Chapter. In this event, the facility will be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. These actual allowable costs will be reported on a complete interim cost report. If this interim report should span June 30, the Agency may accept this report as the interim and regular cost report. In this instance, the report will be used to settle the budgeted period and also to set the next year's prospective rate. If the Agency accepts this report as the June 30 regular report, the due date shall be September 15; if not, the due date will be 60 days after the end of the interim period as specified by the Agency.

(2) The difference between budgeted and/or projected costs in these instances will be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference.

(3) Upon voluntary or involuntary complete withdrawal of a facility participating in the Medicaid program, the provider will be subject to a retroactive adjustment based upon the difference between the amount of reimbursement paid by Medicaid and the actual allowable costs incurred by the former provider during the following periods:

(a) If the effective date of the withdrawal is less than six (6) months after the preceding July 1, a retroactive adjustment will be made for the current fiscal year and for the immediately preceding fiscal year.

(b) If the effective date of the withdrawal is six (6) months or more after the preceding July 1, a retroactive adjustment will be made for the current fiscal year only.

(4) Providers who terminate their participation in the Medicaid Program must provide a final cost report within seventy-five (75) days of terminating their participation in the program. Failure to file this final cost report will result in Medicaid treating all reimbursement for the period covered by the cost report as an overpayment.

(a) Terminating cost reports which are audited by the Agency will be subject to retroactive adjustment. This adjustment (if applicable) will either be paid or recouped by a lump sum payment.

(5) (a) Providers who change their category of care in the Medicaid Program must submit a final cost report for the previous category within seventy-five (75) days of notification from the Agency that a change in the category is authorized. Failure to file this final cost report will result in Medicaid treating all reimbursement for the period covered by the cost report (July 1 to the date of change in category) as an overpayment.

(b) Final cost reports, from the preceding July 1st to the date of change in category from the previous category, will be subject to retroactive adjustment. This adjustment (if applicable) will either be paid or recouped by a lump sum payment. Final cost reports will also be subject to audit by the Agency.

(6) In a transfer which constitutes a change in ownership, the old and new providers shall reach an agreement between themselves concerning trade accounts payable, accounts receivable, and bank deposits. Medicaid will pay the new provider for unpaid claims for services rendered both prior to and after the change of ownership. The new provider shall be liable to Medicaid for unpaid amounts due Medicaid from the old provider.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended July 9, 1984, December 6, 1984, August 9, 1985, May 15, 1990, and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.16. Return on Equity Capital.

Effective September 1, 1991, Return on Equity will no longer be used in rate computation. This does not relieve the provider of the responsibility of maintaining adequate records to account for receivables, prepaids, and payables.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended May 15, 1983, September 8, 1984, June 8, 1985 and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.17. Qualified Retirement Plans.

(1) The reasonable costs of funding "qualified" deferred compensation plans will be recognized as an allowable cost. "Qualified" deferred compensation plans means those plans which have been determined by the Internal Revenue Service to be qualified under Sections 401 or 405 of the Internal Revenue Code, as amended. Such plans can be generally categorized as either a defined benefit (hereinafter called "pension") or defined contribution (hereinafter called "profit sharing") plan.

(2) Under a pension plan, the employer's contributions can be calculated based on the definitely determinable benefits provided for in the plan and such contributions are required without regard to the employer's profits. Pension plans typically provide that forfeitures resulting from termination of employees prior to their becoming one hundred percent (100%) vested in their account balance will be used to reduce further employer contributions, rather than being reallocated among the participants. The reasonable costs of a provider in funding such a pension plan will generally be considered as allowable costs, provided that the plan contains the usual provisions concerning use of forfeitures to reduce employer contributions (and therefore, Medicaid reimbursable costs). The portion of the provider's reimbursed costs under such plans which is attributable to the costs of funding the retirement benefits of employees whose compensation is includable in computing the Administrative and Management costs of this Chapter will be considered as part of the compensation of each such employee during the year of contribution to the plan. For purposes of this Chapter, money purchase pension plan requiring that all forfeitures be used to reduce current or future employer contributions rather than increasing the benefits payable to the participants will be subject to the provisions of this paragraph relating to pension plans rather than the provisions relating to profit sharing plans.

(3) A profit sharing plan is a deferred compensation plan, under which the contributions are based upon the profits of the employer and frequently are completely discretionary with the employer. Therefore, the contributions of the employer cannot be calculated based upon definitely ascertainable benefits to be provided to the employees. The employee, upon retirement, receives whatever amount is in his or her account on that date and is not guaranteed any certain level of retirement income.

(4) Under a profit-sharing plan, forfeitures created by employees terminating employment who are less than one hundred percent (100%) vested in their account balances are typically reallocated to the other participants (including those employees whose compensation falls within the Administrative and Management costs), rather than reducing further contributions by the employer. Therefore, the actual operation of such profit sharing plans could result in a circumvention of the Administrative and Management cost center. Therefore, an employer's contributions to a profit sharing plan will generally be considered a reimbursable cost for Medicaid purposes only if all amounts credited to the accounts of participants who are credited with more than three (3) years of service under the Plan are nonforfeitable.

(5) As with pension plans, all contributions to profit sharing plans which are attributable to employees whose compensation is includable in computing Administrative and Management costs will be included in each such employee's compensation for the year during which the contribution is made to the plan for purposes of calculating the limitations imposed upon Administrative and Management costs under this Code. Provided, however, that in the event amounts attributable to previous Medicaid reimbursements are, under the "forfeiture" provisions of a profit sharing plan, reallocated from the account of an employee not coming under the Administrative and Management cost limitations to the accounts of employees whose compensation is included in computing such limitations, such amounts will be includable in the compensation of the employees to whose accounts such amounts are credited for purposes of computing the Administrative and Management costs for the year of reallocation.

(6) Effective June 15, 1983, Medicaid will not recognize employee stock ownership plans or stock bonus plans that were not both in operation and approved prior to July 1, 1982.

(7) Other types of qualified retirement plans will be considered on a case-by-case basis by Medicaid utilizing the principles contained in this Section to the extent that such principles are consistent with the nature of such plans.

(8) The accrual of costs by a provider under any unfunded deferred compensation arrangement will not be recognized as allowable costs for Medicaid Reimbursement purposes.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended June 23, 1983 and July 9, 1984. Effective date of this amendment October 1, 1990.

Rule No. 560-X-22-.18. Costs to Related Parties.

(1) Allowable costs incurred by a provider for services or goods provided by Related Parties will not exceed the net cost of the services or goods to that Related Party, and that cost cannot exceed the fair market value of the items or services involved.

(2) The provisions of HIM-15 shall be applicable in determining whether a Related Party relationship exists.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Amended October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.19. Receipts Which Offset or Reduce Costs.

(1) Certain income items or receipts must be used to either offset costs or reduce total reported costs. Typical, but not all inclusive, examples of such transactions are:

(a) Purchase discounts, rebates or allowances
(b) Recoveries or indemnities on losses (i.e., insurance proceeds)
(c) Sale of scrap or incidental services
(d) Sale of medical supplies (other than to patients)
(e) Medicare Part B - Income
(f) Sale of meals
(g) Cash contributions and donations designated by a donor for paying specific operating costs

(2) These items may be handled in either of two ways, at the option of the provider:

(a) The cost related to the income can be offset. If this option is selected, the provider must maintain adequate records to support the amount offset.

(b) If all costs associated with the income cannot be or are not identified separately on the cost report and in the provider's books and records, then the total income must be used to reduce total reported costs.

(3) Cash contributions or donations which are not restricted or designated for a specific purpose by the contributor or donor are considered the property of the provider and can be used as they deem appropriate. This income does not have to be offset against any otherwise allowable cost. The provider, however, must keep adequate records to verify the source of such funds and lack of restriction.

(4) Interest earned on restricted funds such as mortgage escrow and/or deposits must be used to offset the interest expense incurred on those loans. Provider records must be adequate to allow verification of all such interest earnings.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended June 23, 1983; July 9, 1984, effective for cost reports for the fiscal year ending June 30, 1985; and October 1, 1990. Emergency rule effective September 12, 1991. Amended December 12, 1991. This amendment effective December 12, 1995.

Rule No. 560-X-22-.20. Chain Operations.

(1) A chain organization consists of a group of two or more nursing facilities which are owned, leased, or through any other device controlled by related organizations or individuals. The home office of a chain organization is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The home office organization will be treated as a "related party" to participating nursing facilities for purposes of this Chapter. Only the home office's actual cost of providing management services is permitted to be allocated to the providers and then only to the extent that they do not duplicate services already provided in the nursing facility. Costs that would not be allowable if directly claimed by a provider will not be allowed as an allocation from a home office.

(2) It is not considered appropriate for the taxpayers of Alabama to pay more for the operation of a nursing facility owned or operated by a chain than would be paid for an individually operated nursing facility. A chain operated facility is expected to be more efficient and economical to operate than an individually operated facility.

(3) If a home office provides centralized laundry, maintenance, and purchasing services to facilities, the actual costs of providing these services will be charged to the facilities to which the services are provided. The facility will report these costs in the appropriate cost center on its cost report.

(4) Maintenance, Central Purchasing, and Laundry

(a) Examples of home office costs associated with providing these services include:

1. Maintenance (Plant Operations Cost Center)
   - (i) Salaries and Benefits
   - (ii) Supplies
   - (iii) Materials
   - (iv) Travel expense subject to limitations contained in Rule 560-X-22-13
2. Central Purchasing (Reported as Other Allowable in lieu of a group purchasing fee)
   - (i) Salaries and Benefits
   - (ii) Goods
   - (iii) Supplies
   - (iv) Materials
   - (v) Travel expense subject to limitations contained in Rule 560-X-22-.13
   - (vi) Building Costs
     - (I) Insurance
     - (II) Rent
     - (III) Lease
     - (IV) Utilities
     - (V) Depreciation
     - (VI) Interest
3. Laundry (Laundry Cost Center)
   - (i) Salaries and Benefits
   - (ii) Supplies
   - (iii) Materials
   - (iv) Travel expense subject to limitations contained in Rule No. 560-X-22-.13

(v) Building costs
(I) Insurance
(II) Rent
(III) Lease
(IV) Utilities
(V) Depreciation
(VI) Interest

(b) Allowable salaries and benefits for these services will be limited to persons directly involved in performing such services. Allowable costs, as defined in this section, which can be identified to a specific member of the chain will be directly allocated to the proper cost center of that facility. The allowable costs not directly allocable should be allocated among the providers (and to any nonprovider activities in which the home office may be engaged) on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits from the costs and in a manner reasonably related to the services received by the entities in the chain. The costs of allocated building space must be used exclusively for these purposes and based on percentage of usage of total square feet. If a separate building is utilized, separate utility meters must be utilized.

(5) Administrative Costs

All costs incurred in maintaining a home office other than maintenance, laundry, purchasing, and corporate nurse costs will be classified as Administrative and Management costs and will be subject to the limitations contained in Rule No. 560-X-22-.10. Allocation of these costs to a facility will be on the basis of patient days. Home offices will report their allocation on lines 5-1 (Salary), 5-2 (Benefits), and 5-17 (Other) on Schedule D of the Uniform Cost Report.

(6) Equity Capital

See Rule No. 560-X-22-.16 of this Code.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amendment effective May 15, 1983. This amendment will apply for cost reports for the fiscal year ending 6-30-83. Amended October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.21. Cost Allocation.

(1) Multiple use facilities, such as hospital-nursing facilities or retirement home-nursing facilities, will allocate all allowable costs which are not directly associated with a specific revenue producing department.

(2) Examples of costs which are usually allocated include, but are not limited to:
(a) Depreciation
(b) Administrative and General
(c) Employee Health and Welfare
(d) Plant Operations
(e) Laundry and Linen
(f) Housekeeping
(g) Medical Records
(h) Dietary
(i) Social Services
(j) Pharmacy

(3) Examples of revenue-producing departments are:
(a) Retirement Home
(b) Nursing Facility
(c) Hospital Facility

(4) Certain cost items must be identified and allocations of those items to various cost centers must be adjusted so that the total cost allocated will be reported on the specific cost report lines as applicable. These costs are:
(a) Medical Records Cost
(b) Consultant Fees
(c) Medical Directors Fees
(d) Depreciation Expense
(e) Interest Expense
(f) Property Taxes & Insurance
(g) Raw Food

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Amended October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.22. Unallowable Expenses.

(1) General

(a) All payments to providers for services rendered must be based on the reasonable cost of such services covered by the Alabama State Plan. It is the intent of the program that providers will be reimbursed the reasonable costs which must be incurred in providing quality patient care. Implicit in the intent that reasonable costs be paid are the expectations that the provider seeks to minimize costs and that costs do not exceed what a prudent and cost-conscious buyer pays for a given item of service or product. If costs are determined to exceed the level that prudent buyers incur in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not allowable.

(b) Costs related to patient care include necessary and proper costs involved in developing and maintaining the efficient operation of patient care facilities. Necessary and proper costs related to patient care are those which are usual and accepted expenses of similar providers.

(2) Costs Covered by Other Programs. Costs that are covered by other State and/or Federal programs will not be allowed, and costs which are covered by other Alabama Medicaid Agency programs will not be reimbursed under the Nursing Home Program. Examples of such costs include, but are not limited to:
(a) Prescription Drugs
(b) Dental Expense (except consultant fees)
(c) Physicians' Fees other than those required by licensure
(d) Laboratory Expense for Patients
(e) Physical Therapy
(f) Oxygen (except for concentrators)
(g) Ambulance Service
(h) Occupational Therapy
(i) Inhalation Therapy
(j) Speech Therapy
(k) Group Therapy
(l) Medicare Part B Supplies

(3) Administrative Costs. Items of administrative costs which will not be allowed are listed below. This listing is not intended to be all inclusive. Other administrative costs which violate the prudent buyer concept or are not related to patient care will not be reimbursed by the Alabama Medicaid Agency.

(a) Management Fees

1. Management firms, individuals and consultants which duplicate services already provided, or in a facility in which a full-time licensed administrator is employed. Excluded from this rule are those management contracts required incident to a bond issue for a valid business purpose.

(b) Director's Fees and Other than Nominal Meeting Expenses

(c) Compensation to owners and other personnel not performing necessary functions (See Rule No. 560-X-22-.10)

(d) Salaries which are paid to personnel performing overlapping or duplicate functions

(e) Legal Fees and Expenses
1. Retainers
2. Relating to informal conference and fair hearings
3. Relating to issuance and sale of capital stock and other securities
4. Relating to creation of corporations or partnerships
5. Relating to business reorganization
6. Services for benefits of stockholders
7. Acquisition of nursing facilities or other business enterprises
8. Relating to sale of nursing facilities and other enterprises
9. In connection with criminal actions resulting in a finding of guilt or equivalent action or plea
10. Other legal services not related to patient care

(f) Outside Accounting and Audit Fees and Expenses
1. Personal tax returns
2. Retainers
3. Relating to informal conferences and fair hearings
4. Relating to issuance and sale of capital stock and other securities
5. Relating to creation of corporations or partnerships
6. Relating to business reorganization
7. Services for the benefits of stockholders
8. Acquisition for nursing facilities or other business enterprises
9. Relating to sale of nursing facilities and other enterprises
10. In connection with participation in criminal actions resulting in guilt or equivalent action or plea
11. Feasibility studies related to acquisition costs obtained after 10/1/84 (See Rule No. 560-X-22-.14(9)(g)
12. Other Accounting services not related to patient care

(g) Taxes
1. Personal income
2. Property not related to patient care
3. Corporate income tax
4. Vehicle tag & tax

(h) Dues
1. Club
2. Civic
3. Social
4. Professional organization dues for individuals unless employment of individual negates need for qualified consultants
5. Non-patient care related organization

(i) Insurance
1. Life

2. Personal property not used in patient care
3. On real estate not used in providing patient care
4. Group life and health insurance premiums which favor owners of a provider or are for personnel not bona fide employees of the facility

(j) Advertising in excess of the limitations of Rule No. 560-X-22-.10 of this Chapter

(k) Chaplains/Spiritual Advisors

(1) Special assessments from Nursing Home Association

(m) Bad debts and associated collection expenses

(n) Employment Agency/Employee Search Fees for other than Administrator and direct care personnel

(o) Employees relocation expenses

(p) Penalties

1. Late Tax
2. Late payment charges. (Note: If a facility can fully document that a late payment charge is directly due to late Medicaid payments, the amount of the late payment charge will be an allowable cost.)
3. Bank overdraft
4. Fines

(q) Certain Real Estate Expenses

1. Appraisals obtained in connection with the sale or lease of a Nursing Facility (unless required by Medicaid)
2. Costs associated with real estate not related to patient care

(r) Interest Expense

1. Interest associated with real estate in excess of nursing facility needs or real estate not related to patient care
2. Interest paid to unrelated parties on working capital loans will be limited to no more than 90 days interest on an amount not in excess of two months average allowable cost per cost reporting period
3. Interest expenses applicable to penalties
4. Construction Interest (must be capitalized)
5. Interest paid to a related party
6. Interest on personal property not related to patient care
7. Interest on loans not associated with patient care
8. Interest expense generated by the refinancing of any long term debt that exceeds the amount which would have been allowed had refinancing not occurred unless such excess interest meets the necessary and reasonableness tests of Rule No. 560-X-22-.11(1)

(s) Licenses

1. Consultants

(t) Donations and Contributions

(u) Accreditation Surveys

(v) Telephone Services

1. Mobile telephones, beepers, (except for Directors of Nursing or Maintenance personnel), telephone answering and recording devices, telephone call relays, automated dialing services, and off premise telephones
2. Long distance telephone calls of a personal nature

(w) Organizational and Start-up Costs - All costs related to the issuance and sale of shares of capital stock, including underwriters' fees and commissions, accounting or legal fees incurred in establishing the business organization, costs of qualifying with the appropriate Federal or State Authorities, stamp taxes, etc., expenses of temporary directors, costs of organizational meetings of directors and/or stockholders, incorporation fees.

(x) Any costs associated with corporate stock records maintenance.

(4) Prior Period Costs and Accounts Payable

(a) The Medicaid reimbursement rate is calculated to provide adequate funds to pay business expenses in a timely manner. Costs incurred in prior periods but not paid must be accrued and reported in that period during which the costs were incurred. Payment of prior period cost in the current year is not an allowable cost. Exceptions will be allowed, based on reasonableness, for small invoices which, in total, do not exceed $500.00 per fiscal period. These invoices must be as a result of no fault of the provider. Any pattern of abuse will cause the costs in question to be automatically disallowed by the Agency.

(b) Short-term liabilities must be paid within ninety (90) days from the date of invoice; otherwise, the expense will not be allowed unless the provider can establish to the satisfaction of Medicaid that the payment was not made during 90 days for a valid business reason.

(c) Actual payment must be made by cash or negotiable instrument. For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and must be payable to order of or to bearer. All voided instruments, whether voided in fact or by devise, are considered void from inception.

(d) A provider who files for and is awarded protection under Chapter 11 of the Federal Bankruptcy Code may be given consideration in a current year cost report for actual payment of prior period allowable costs which have been disallowed in prior period cost reports due to failure to make actual payment of the cost claimed. In order for payment of these prior year allowable costs to be considered under a current year cost report, they must have been paid pursuant to a court approved plan for reorganization under Chapter 11 of the Federal Bankruptcy Code. The allowable costs will not include any interest or penalty incurred for failure to make payment in the prior year. The agency will not reimburse interest expense generated from loans incurred to pay any such allowable prior period costs. Any such (untrended) allowable cost per day shall be added to the per diem rate after the normal rate setting process. It will be subject to the various cost ceilings, thus the providers cost must be below the ceilings for any possible reimbursement of these prior period costs to occur.

(5) Non-Covered Services

(a) The costs of providing personal services and costs associated with income producing activities are not allowable and must be eliminated from cost. If all costs associated with the service or activity cannot be, or are not identified separately on the cost report, then the total income which was generated must be used to offset total reported costs.

(b) Examples of these services or activities are laundry and dry cleaning of personal apparel (subject to the provisions of Rule 560-X-22-.12), radio, television, telephone, and vending machines.

(c) The following are examples of costs associated with non-covered services or activities which are not reimbursable:

1. Materials or goods
2. Supplies
3. Salaries and Employee Benefits
4. Applicable Fair Rental payment

(6) Beauty and Barber Services

(a) If the nursing facility makes no charge to the patient for beauty and barber services, and if this service is performed by employees of the facility or by volunteers, then the costs associated with the service are allowable for Medicaid reimbursement purposes.

(b) If the nursing facility makes a charge to the patient for beauty and barber services and if all costs associated with the service or activity cannot be, or are not identified separately on the cost report, then the total income which was generated from the service must be used to reduce or offset total reported costs.

(7) Miscellaneous or Other Non-Allowable Expenses. The following is a list of expenses which have previously been submitted in cost reports that are unallowable. It is intended to typify unallowable transactions and is not intended to be all-inclusive:

(a) Nursing consultants, except those required by OBRA 87 requirements

(b) Additional wages paid as a result of an audit by the Wage and Hour Administration which relate to a prior period. However, additional payments made as the result of workman's compensation audits conducted after the end of the relevant fiscal year will be considered allowable costs for the fiscal year in which such payments are made.

(c) Newspaper or magazine subscriptions in excess of $250.00.

(d) Off premise telephone service

(e) Farm expense

(f) Real estate costs associated with real estate ownership in excess of nursing facility needs and not related to patient care

(g) Sitter services or private duty nurses

(8) Gifts. The cost of gifts made by a provider in excess of $20.00 per bona fide facility employee per fiscal year is an unallowable expense.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended May 15, 1983; July 9, 1984, June 14, 1988, April 14, 1990, and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991. Amended August 12, 1992.

Rule No. 560-X-22-.23. Cost Reports.

(1) Extensions. Each provider is required to file a complete uniform cost report for each fiscal year ending June 30th. The complete uniform cost report must actually be received by Medicaid on or before September 15th. Should September 15th fall on a state holiday or weekend, the complete uniform cost report will be due the next following working day. Cost reports shall be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by the nursing facility. Extensions may be granted only upon written approval by Medicaid for good cause shown. An extension request must be in writing, contain the reasons for the extension, and must be made prior to the cost report due date. Only one extension per cost reporting year will be granted by the Agency. Extensions in excess of thirty (30) days will not be granted. For cost reports due September 15, 1991 and 1992, extensions of only fifteen (15) days will be authorized, but only in cases of extreme hardship.

(2) Penalties. If a complete uniform cost report is not filed by the due date, or an extension is not requested or granted, the provider shall be charged a penalty of one hundred dollars per day for each calendar day after the due date; this penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting documentation.

Once a cost report is late, Medicaid shall suspend payments to the provider until the cost report is received. A cost report that is over ninety (90) days late may result in suspension of the provider from the Medicaid program. Further, the entire amount paid to the provider during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The provider will have thirty (30) days to either refund the overpayment or file the delinquent cost report after which time Medicaid may institute a suit or other action to collect this overpayment amount or the delinquent cost report.

(3) Each uniform cost report will be signed by the provider, and if the cost report is prepared by anyone other than the provider or a full-time employee of the provider, such person shall execute the report as the Cost Report Preparer. The signatures of both the provider and Cost Report Preparer, if any, must be preceded by the following certification: I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared on behalf of (Provider name(s) and number(s)) for the cost report period beginning and ending , and that to the best of my knowledge and belief, it is a true, correct, and report prepared from the books and records of the provider(s) in accordance with applicable Medicaid Reimbursement Principles, except as noted.

Signed
Officer or Administrator
of Provider(s)

Cost Report Preparer

By:
Title

Date Date

(4) Any cost report received by Medicaid without the required original signatures and/or without the required certification(s) will be deemed incomplete and returned to the provider.

(5) Cost reports should be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by providers. Cost reports will be deemed immutable with respect to the reimbursement for which the provider is entitled for the next succeeding fiscal year, one year from the date of its receipt by Medicaid, or its due date, whichever is later. Providers will have this one year period within which to resubmit their cost reports for the purpose of correcting any material errors or omissions of fact. This one year limitation does not apply to adjustments in cost reports that are initiated by Medicaid. Medicaid retains the right to make adjustments in cost reports at any time a material error or omission of fact is discovered.

(6) Providers who terminate their participation in the Medicaid program, by whatever means, must provide a written notice to the Agency thirty (30) days in advance of such action. Failure to provide this written notice shall result in a one hundred dollar ($100) per day penalty being assessed for each day short of the 30 day advance notice period (up to a maximum of $3,000). Terminating providers must file a final cost report within seventy-five (75) days of terminating their participation in the program. Final payment will not be made by the Medicaid Agency until this report is received. Failure to file this final cost report will result in Medicaid deeming all payments covered by the cost report period as overpayments until the report is received. Additionally, a penalty of one hundred dollars ($100.00) will be assessed for each calendar day that the cost report is late.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended July 9, 1984, June 10, 1987 and July 12, 1988, February 13, 1990, and October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.24. Accounting Records.

(1) The provider must submit adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be presented on the accrual basis of accounting. This basis requires that revenue must be allocated to the accounting period in which it is earned and expenses must be charged to the period in which they are incurred, regardless of when cash is received or disbursed.

(2) Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for supplies, services, or assets. This includes all ledgers, books, records, and original evidence of costs which pertain to the costs reported. Financial and statistical records should be maintained in a consistent manner from one period to another; however, the regard for consistency should not preclude a desirable change in accounting procedures provided that full disclosure of significant changes is made.

(3) The following records and documentation must be kept by the provider and must be available for audit inspection by Medicaid:

(a) General Ledger
(b) Disbursements Journal
(c) Cash Receipts Journal
(d) Payroll Journal
(e) Working Trial Balance and Adjusting Entries
(f) Patients Personal Funds Records
(g) Patient Admission and Discharge records
(h) Purchases Journal (For facilities larger than 100 beds)

(4) All information contained in the provider's General Ledger must be capable of audit verification. Disbursements must be supported by invoices which detail the quantity and price of goods and services purchased, together with evidence that such goods and/or services were received. Disbursements made without proper documentation will not be allowable for Medicaid reimbursement purposes. This documentation should be filed in chronological order, either alphabetically or in some other reasonable manner capable of being audited. Payroll journals must be supported by time cards or other documentation signed by the employee and verified by his/her department head. Each time card or other documentation must also indicate the hours worked by the employee, the rate of pay for the services rendered by the employee, and must be identified by the cost center, to which the expense should be charged. If an employee works in more than one area, the expense should be charged to more than one cost center, and the expenses should be allocated to the centers in the same ratio as the work is performed, with a notation made to explain the allocation.

(5) Subsidiary records which must be kept by the provider and be readily available for audit and inspection include, but are not limited to:

(a) Accounts Receivable ledger sheets or cards which agree with the General Ledger control account (to include June 30 aging schedules)
(b) Accounts Payable Ledger sheets or cards which agree with the General Ledger control accounts (to include June 30 aging schedules)
(c) Notes Receivable
(d) Notes Payable
(e) Long-Term Debt evidenced by amortization schedules and copies of the original debt transaction
(f) Insurance policies together with invoices covering the fiscal year reported
(g) Depreciation Schedules showing the cost of the facility and equipment
(h) Payroll Tax Returns
(i) Income Tax Returns
(j) Census Records (See Schedule 8A)

(k) Bank Statements, cancelled checks, deposit slips, voided checks, and bank reconciliations

(l) A signed copy of the current lease

(m) Automobile travel logs

(6) Petty Cash Funds shall be maintained under the Imprest System. The disbursement of these funds shall be substantiated by an invoice and/or voucher detailing the date of disbursement, expense category, and name of person disbursing the funds.

(7) All documents, work papers, and schedules prepared by or on behalf of the provider which substantiate data in the cost reports must be made available to Medicaid auditors and investigators upon request.

(8) The provider will provide adequate desk space and privacy to Medicaid auditors and investigators during the progress of audits. The provider's personnel or personnel representing an outside independent accountant may be present at a Medicaid audit and be allowed access to the Medicaid auditors and workpapers only at the invitation and discretion of the Medicaid auditors during the course of their work at the provider's establishment.

(9) In the event a Medicaid auditor or investigator is denied access to a nursing facility's provider's records, the provider will be advised of the contract provisions governing inspection and review of these records by authorized representatives. The provider will be advised that if access to records is not granted, the provider will be given ten (10) calendar days in which to furnish the records to Medicaid at its Montgomery offices. If a provider fails to comply within the ten (10) day period, Medicaid will reduce all subsequent reimbursement payments by the costs it has been unable to substantiate.

(10) If the provider fails to keep the minimum financial records required to properly substantiate reported costs, the provider will be in violation of the provider agreement and will be subject to termination from the Medicaid program.

(11) All books and records required to be kept and made available to Medicaid personnel by a provider will be made available at the nursing facility unless this requirement is specifically waived in writing in advance by Medicaid.

(12) If a provider who has been given three (3) full working days notice of an audit fails to make the required records, including any not maintained at the facility, available at that facility, the Medicaid auditor(s) will return to his (their) office, and the provider will be given ten (10) calendar days to present all of the accounting records at the Medicaid office. Should the provider fail to present all of the accounting records at the Medicaid office during the allotted time period, Medicaid will consider all payments made to the provider during the time period covered by the records sought to be audited to be overpayments and may proceed to recover those overpayments from the provider.

(13) If Medicaid is required to go out of state for an audit, the organization being audited will bear all expenses and costs related to the audit, including, but not limited to, travel and reasonable living expenses, and those costs will not be allowable on any subsequent cost report.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended July 9, 1984. Effective date of amendment October 1, 1990.

Rule No. 560-X-22-.25. Patient Personal Fund Accounts.

(1) Personal Fund Management. In accordance with Federal Regulations for Medicare and Medicaid Facilities, a Medical Assistance patient may manage his personal affairs unless a facility accepts the patient's delegation of this responsibility. A patient managing his personal affairs may voluntarily have a facility hold custody of his funds.

(2) Voluntary Patient Delegation of Responsibility to the Facility. There are three (3), and possibly more, specific categories of Medical Assistance patients who may voluntarily delegate to the facility the management of personal financial affairs.

(a) Persons receiving Social Security checks or other income which is applicable under Medical Assistance to the cost of services less a thirty dollar ($30.00) per month personal care allowance.

(b) Persons receiving a check from the Department of Human Resources for a twenty-three dollar ($23.00) per month personal care allowance.

(c) Persons receiving donated funds from their family or friends which are not applicable to the cost of services. In the event these persons voluntarily delegate the management or custody of such funds to the facility, proper management and accountability for the funds must be provided by the facility.

(3) Establishment of a General Patient Fund Account

(a) All patient funds for which the facility has accepted delegation or legal responsibility will be maintained in a separate General Patient Fund Account, which may also include the funds of persons who are not under the Medical Assistance Program.

(b) Receipts, disbursements, and earned interest will be debited and credited to this account. The separate account is required to assure that personal funds of patients are not co-mingled with other facility accounts and records. Maintenance of the personal fund account is considered to be a normal function of the administrative staff, and no additional personnel will be authorized for reimbursement purposes.

(c) The facility must purchase a surety bond to guarantee the security of all personal funds of residents entrusted to the institution.

(4) Endorsements, Receipts, and Deposits

The facility shall present checks or other receipts for moneys to the patient for his personal endorsement prior to depositing them in the facility's General Patient Fund Account. If funds received by the facility do not require endorsement, the facility will insure that all such funds are properly posted in the individual Patient Subsidiary Ledger. Unless prior written authorization is given by the patient or his/her guardian, a voucher or other form of documentation showing the date, amount, and proper authorizing signature for each transaction shall be retained by the facility.

(5) Expenditure of Funds from the General Patient Fund Account

(a) A facility may not use a Medical Assistance Patient's personal funds to supplement a payment for nursing care. A facility that fails to comply with this regulation will be subject to prosecution under Federal and State laws.

(b) Also, a facility may not bill a patient for undelivered personal services such as manicures, haircuts, hair styling, laundry, and dry cleaning.

(c) The facility may not automatically use the patient's funds as a partial or complete payment to the facility for non-covered services such as laundry or beauty/barber services. Before such use can be made of these funds, the facility must have the written consent of the patient or his/her legal guardian.

(d) Within thirty (30) days after discharge or transfer of the patient to another facility, all remaining funds for the patient shall be returned by check to the patient or the patient's legally responsible relative or legal guardian.

(e) In case of death, all remaining funds shall be returned by check to the patient's estate. If there are no known heirs or estate, the facility may turn over these funds under the provisions of the Uniform Disposition of Unclaimed Property Act Alabama Code Section 35-12-20 through 35-12-48) by filing the appropriate forms (UP-1, UP-2), along with the properly identified funds to the Alabama Department of Revenue, Unclaimed Property Section. The forms may be obtained from the Alabama State Revenue Department. Proper delivery of funds under the terms of the above statute relieves the facility of liability for such funds.

(6) Accounting Records to be Maintained. A facility shall maintain the following records relative to the receipt and expenditure of a Medical Assistance patient's funds.

(a) General Patient Fund Account

1. The facility shall maintain a separate accounting record for the General Patient Fund Account. This accounting record may be maintained in the General Ledger. The total of all patient's funds shall be reflected in this account, except funds transferred to a savings account.

2. The total patient's funds record shall be reconciled to the bank statement each month.

(b) Individual Patient Subsidiary Ledger

1. An Individual Patient Ledger, which may be a card or computer record, shall be maintained for each Medical Assistance patient for whom the facility has accepted the responsibility for personal funds. If a computer record is maintained, a quarterly printout is required and should include the same information as is required on the card.

2. The Medical Assistance patient's full name and Medicaid number are to be entered on the form. All deposits and disbursements are to be recorded in chronological order.

(c) General Ledger Interest Bearing Account of Total Patient Funds

1. The facility must deposit in a Federally insured interest bearing account all funds in excess of $50.00 per recipient. Amounts less than $50.00 per patient may be maintained in either a petty cash fund or a non-interest bearing account.

2. An account of the total amount of patient's funds is to be maintained by the facility.

3. The facility may use interest earned on patient funds to meet the costs of maintaining the patient funds. If, however, the interest earnings are less than the maintenance charges (charges imposed by the bank) the facility may not use patient funds to cover the difference.

4. Interest as earned must be posted to each resident's account upon notification by the financial institution of such earnings as appropriate. Earned interest will not be spent for patient care or services required to be provided by the facility under Federal and State regulations.

(d) Petty Cash Fund Records

1. Facilities that maintain a petty cash fund to disburse small amounts of money to patients shall credit the total withdrawal of such funds to the General Patient Fund Account described previously.

2. When the Petty Cash Fund is replenished, the amounts of the disbursements shall be posted to the Individual Patient Subsidiary Ledger.

(e) Inadequate Records. When individual patient subsidiary ledgers or records do not reconcile with the Patient Personal Fund Bank Accounts and/or control account, the patient's funds are co-mingled with facility funds, or when any other situation exists in which auditors are unable to determine correct balances and/or separation of the patient personal funds, an income offset adjustment for any difference shall be made against other allowable reported costs of the provider. The adjustment (if any) will be determined during the course of an audit in accordance with generally accepted accounting principles and auditing standards.

(f) When the balance in a Medical Assistance patients' personal fund account accumulates to within $200.00 of the resource limit as established by Medicaid, the facility must give written notice to the patient and/or his/her legal guardian of the possibility of losing Medicaid eligibility and the options available to him.

(7) Reporting of Patient's Funds Quarterly Report to patient. In accordance with Federal regulations, at least once every three (3) months, the facility will give the patient, or the patient's legally responsible relative or legal guardian, a copy of the Individual Subsidiary Patient Ledger Card or computer printout listing all deposits, disbursements, and the current balance.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended August 10, 1983. Emergency Rule effective July 1, 1988. Amended July 12, 1988 and May 15, 1990. Effective date of this amendment October 1, 1990.

Rule No. 560-X-22-.26. Audit Adjustment Procedures.

(1) Audit adjustments will be paid or collected by a combination of (1) changing the per diem rate of the facility and (2) a lump sum settlement for the amount under/over paid for the period prior to the effective date of the per diem rate change.

(2) Under/Overpayment situations arising from the audit of a terminating cost report will be paid or recouped by a lump sum settlement.

(3) All adjustments will be subject to the limitations set out in this Chapter and subject to the appropriate ceilings.

(4) Collection procedures will be applied only after the facility has been given thirty (30) days in which to disagree with any of the disallowances contained in the report of audit.

(5) A final audit computation sheet (See Schedule 25-A at Rule No. 560-X-22-.26(5)) will be forwarded to each facility with the report of audit. An adjusted per diem rate will be stated in the report of audit and will be computed based on the audit adjustment. This new per diem rate will be effective for billing purposes on the 1st day of a month, allowing for the thirty (30) day notification period and a reasonable amount of time for processing the report of audit. The effective date of the rate change will be shown in Item I of the final audit computation worksheet. The remaining portion of the audit settlement will be collected or paid in a lump sum amount as shown in the final audit computation sheet for items II, III, and IV. This lump sum amount for the months prior to the effective date (underpayment or overpayment period) of the rate change is computed by applying the adjustment per patient day (Part II) to the total Medicaid days in the overpayment/ underpayment period (Part III,e). The lump sum amount due to the provider or Medicaid is shown on the last item in Part IV.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended December 6, 1984. Effective date of amendment October 1, 1990.

Rule No. 560-X-22-.27. Appeals.

(1) Facility administrators who disagree with the findings of the Medicaid desk audits or field audits may request, in writing, an informal conference at which they may present their positions. Such written requests must be received by Medicaid within thirty (30) days of the date on which Medicaid mails the audit report, or new reimbursement rate, as the case may be, to the provider.

(2) Administrators who believe that the results of the informal conference are adverse to their facility may ask, in writing, for a Fair Hearing, which will be conducted in accordance with Medicaid Regulations. Such written requests must be received by Medicaid within fifteen (15) days of the date on which Medicaid mails to the provider its determination on the issues presented at the informal conference.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Amended October 1, 1990. Emergency rule effective September 12, 1991. Rule effective December 12, 1991.

Rule No. 560-X-22-.28. Negligence Penalty.

(1) Whenever an overpayment of Medicaid reimbursement received by a provider from Medicaid results from the negligence or intentional disregard of Medicaid Reimbursement Principles by the provider or its representatives (but without intent to defraud), there will be deducted from any reimbursement thereafter due the provider a penalty equal to 5% of such overpayment.

(2) If any part of such an overpayment by Medicaid to the provider is due to fraud on the part of the provider or any of its representatives, there will be deducted from any subsequent reimbursement due the provider on proof of fraud, a penalty equal to 50% of the overpayment.

(3) The penalties imposed under Rules No. 560-X-22-.28(1) and (2) of this Code shall be in addition to and shall in no way affect Medicaid's right to also recover the entire amount of the overpayment caused by the provider's or its representative's negligence or intentional disregard of the Medicaid Reimbursement Principles or fraud.

(4) Whenever the cost of a good or service has been previously disallowed as the result of a desk audit of a provider's cost report and/or a field audit by Medicaid and such cost has not been reinstated by voluntary action of Medicaid, as the result of an administrative hearing, or by a Court Order, such costs shall not thereafter be included as an allowable cost on a Medicaid cost report. The inclusion by the provider or its representative of such a cost on a subsequent cost report, unless the provider is actively pursuing an administrative or judicial review of such disallowance, will be considered as negligent and/or intentional disregard of the Medicaid Reimbursement Principles and subject to the 5% penalty imposed by Rule No. 560-X-22-.28(1) of this Code based upon the amount of overpayment which has or which would have resulted from the inclusion of such cost had its inclusion not been detected. Such inclusion shall also be subject to the provisions of Rule No. 560-X-22-.29 relating to intentional or negligent disregard of the Medicaid Reimbursement Principles.

(5) For purposes of the preceding paragraph, a provider shall be considered as having included a previously disallowed cost on a subsequent year's cost report if the cost included is attributable to the same type good or service under substantially the same circumstances as that which resulted in the previous disallowance. Examples of such prohibited inclusions include, but are not limited to:

(a) Inclusion of the portion of rental payment previously disallowed as being between related parties

(b) Inclusion of an amount of compensation which has previously been disallowed as unreasonable during a prior period

(c) Inclusion of a cost not related to patient care which has previously been disallowed

(d) Improper classification or allocation of costs to cost centers

(6) Rule No. 560-X-22-.28(4) shall NOT be interpreted as indicating that a provider's or his representative's initial entry of a cost item on a cost report will not be treated as a negligent or intentional disregard of the Medicaid Reimbursement Principles.

(7) Any provider who knowingly files or allows to be filed a cost report which has been prepared by a person who has been suspended as a Cost Report Preparer during his period of suspension, shall be subject to termination of its provider agreement, and, in addition, subsequent reimbursement otherwise due the provider shall be reduced by $1400.00, as though the cost report had not been received by Medicaid during the fourteen (14) day period following the due date for filing such report. (See Rule No. 560-X-22-.23)

(8) Providers and their representatives who are uncertain as to whether the inclusion of a cost in a cost report is in violation of the Medicaid Reimbursement Principles should footnote or otherwise call attention to the entry in question and specifically disclose the dollar amount and the portion of the cost report entry as to which they are in doubt.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Amended October 1, 1990.

Rule No. 560-X-22-.29. Cost Report Preparers.

(1) Cost Report Preparers. "Cost Report Preparer" includes any person (including a partnership or corporation) who, in return for compensation, prepares or employs another to prepare all or a substantial portion of a Medicaid cost report. A Cost Report Preparer can include both the actual preparer of the report as well as his or her employer. Where more than one person aids in filling out a Medicaid cost report, the one who has primary responsibility for the preparation of the report will usually be a preparer, while those involved only with individual portions of the report will usually not be preparers. Any person who supplies enough information and advice so that the actual completion of the return is a mere mechanical or clerical matter is a Cost Report Preparer even though the person doesn't actually place or review the placement of the information on the cost report.

(2) Refusal of Cost Reports. Medicaid will refuse to accept cost reports prepared by a Cost Report Preparer who:

(a) Has shown a pattern of negligent disregard of the principles established by or incorporated by reference into this Code;

(b) Prepares a cost report evidencing an intentional disregard of the Medicaid Reimbursement Principles;

(c) Has given false or misleading information, or participated in giving false or misleading information to any Medicaid employee, the Alabama Medicaid Agency, or to any hearing officer authorized to conduct hearings with regard to Medicaid reimbursement issues, knowing such information to be false or misleading. "Information" includes facts or other information contained in testimony, Medicaid Cost Reports, financial statements, affidavits, declarations, or any other documents or statements, written or oral.

(d) Medicaid will treat any cost report prepared by a Cost Report Preparer who has been determined to be ineligible to prepare Medicaid cost reports as incomplete and shall promptly return any such Cost Report to the provider on whose behalf the report has been prepared. The receipt by Medicaid of such cost reports shall not satisfy, suspend, or stay the requirements of this Chapter relating to the timely filing of Medicaid Cost Reports.

(3) Determination of Eligibility.

(a) Upon receipt by any Medicaid employee of information indicating that a Cost Report Preparer may have engaged in conduct which could result in the refusal by Medicaid to accept cost reports prepared by such preparer under Rule No. 560-X-22-.29(2) of this Section, such information shall be promptly reported to Medicaid's Director of Provider Audit who shall insure that an informal inquiry is made regarding the reliability of such information. Medicaid legal counsel and/or appropriate representatives of the Attorney General's office shall be consulted, as deemed appropriate.

(b) Informal Inquiry.

1. If the Medicaid Director of Provider Audit, based upon such informal inquiry, determines that there is substantial evidence that the preparer has engaged in conduct specified in Rule 560-X-22-.28, he will give written notice to the preparer which will offer the preparer the opportunity to refute such information or allegations. If the preparer fails to provide the Director of Provider Audit with information which results in a determination by the Director that the evidence of misconduct is insufficient to justify suspension, the Director will, at the preparer's request, have a hearing arranged and will have the preparer notified that such an administrative hearing will be held with regard to the alleged misconduct.

2. Should the preparer fail to deny or provide documentation or information to refute the allegations made against him within thirty (30) days after the date of the mailing of the initial letter to the preparer, such allegations will be deemed to be admitted, and the preparer will have waived his right of hearing. The Director of Provider Audit will then notify the preparer of his suspension under this rule.

3. The above-described hearing will be set for a time no earlier than thirty (30) days after the date of the mailing of the initial letter to the preparer.

(c) Procedures Related to Informal Inquiry.

1. Notice. The initial notice from the Director of Provider Audit to the preparer will describe with sufficient specificity the allegations being made against him to allow him to respond to those allegations in a specific manner.

2. The Notice of Hearing. The notice of hearing to the preparer will repeat the allegations which constitute the basis for the proceedings and state the date, time, and place of the hearing. The hearing, as noted in Rule No. 560-X-22-.29(3)(b)1 above will be arranged only at the request of the preparer. Such notice shall be considered sufficient if it fairly informs the preparer of the allegations against him so that he is able to prepare his defense. Such notice may be mailed to the preparer by first class or certified mail, addressed to him at his last address known to the Director of Provider Audit. A response or correspondence from the preparer or his representative shall be mailed to Director of Provider Audit, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104.

3. Answer. No written answer to the notice of hearing shall be required of the preparer.

4. Hearing. The hearing shall be conducted in accordance with Medicaid's Regulations related to Fair Hearings. (Chapter 3 of the Alabama Medicaid Administrative Code.)

5. Failure to Appear. If the preparer fails to appear at the hearing after notice of the hearing has been sent to him, he shall have waived the right to a hearing and the Commissioner of Medicaid may make his or her determination without further proceedings.

6. Determination of Ineligibility. The determination of the ineligibility of a Cost Report Preparer to prepare Medicaid cost reports will lie solely with the Commissioner of Medicaid. The Commissioner will make such determination after giving due consideration to the written recommendation of the Hearing Officer, unless the preparer has waived his right to hearing, in which event there need be no recommendation by the Hearing Officer.

7. Notification of Ineligibility. If the determination of the Commissioner is that the preparer shall no longer be eligible to prepare Medicaid cost reports, the preparer shall be notified in writing, and the preparer shall thereafter not be eligible to prepare such reports unless and until authorized by the Commissioner of Medicaid to do so. Such a preparer shall IN NO EVENT be eligible to prepare such cost reports during the two (2) year period immediately following his suspension. Any person who acts as a Cost Report Preparer during his period of suspension shall not thereafter be eligible to act as a Cost Report Preparer for a period of ten (10) years from the date of his original suspension. Any provider who knowingly allows a cost report to be prepared by a person who has been suspended under this Section will be subject to having its provider agreement cancelled and will be subject to the applicable penalties of Rule No. 560-X-22-.28 of this Code.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.200 - .272, et seq. Rule effective October 1, 1982. Amended September 9, 1988. Effective date of this amendment October 1, 1990.

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Chapter 23 Hospital Reimbursement Program.

Rule No. 560-X-23-.01 Introduction

(1) This Chapter of the Alabama Medicaid Administrative Code has been promulgated by the Alabama Medicaid Agency (Medicaid) as a guide for providers of Medicaid hospital care. This Chapter is applicable to all hospitals participating in the Alabama Medicaid Program.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: February 9, 1988. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.02 Definitions and Basic Concepts

(1) Access Payment: A payment by the Medicaid program to an eligible hospital for inpatient and outpatient hospital care provided to a Medicaid recipient. The access payment will be made contingent upon the assessment tax required by Ala. Code (1975) §40-26B-70, et seq. being collected.

(2) Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a facility, which is licensed as a hospital under the laws of the State of Alabama, provides 24-hour nursing services, and is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled.

(3) Medicare Cost Report: The electronic cost report (ECR) filing of the CMS Form 2552-96 Hospital and Hospital Health Care Complex Cost Report, as defined in CMS Provider Reimbursement Manual (PRM) 15-II (hereinafter referred to as "Form CMS 2552-96) and all accompanying schedules, forms and supporting information.

(4) Privately Owned and Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama other than:

(a) Any hospital that is owned and operated by the federal government;

(b) A hospital that is a state agency or unit of state government, including without limitation a hospital owned by a state agency or a state university.

(c) A hospital created and operating under the authority of a governmental unit which has been established as a public corporation pursuant to Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned and operated by a unit of local government.

(d) A hospital that limits services to patients primarily to rehabilitation services as authorized by Alabama Administrative Code 410-2-4-.08; or

(e) A hospital granted a Certificate of Need as a Long Term Acute Care Hospital as defined by Alabama Administrative Code 410-2-4-.02(8).

(5) Non State Government Owned and Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama created or operating under the authority of a governmental unit which has been established as a public corporation pursuant to Ala. Code, Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned or operated by a unit of local government.

(6) State Owned or Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama that is a state agency or unit of state government, including without limitation a hospital owned or operated by a state agency or a state university.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: October 11, 1986; September 9, 1987; May 25, 1988; November 10, 1988; April 14, 1989. **Amended**: Emergency Rule effective October 1, 1991. **Amended**: January 14, 1992; September 11, 1992, May 13, 1993, January 11, 1996. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.03 Inpatient Medicaid Base Payment

(1) For the period October 1, 2009, through September 30, 2011, each hospital shall receive an inpatient Medicaid base (per diem) payment, in accordance with the following:

(a) Medicaid shall pay each hospital as a base (per diem) amount for state fiscal years 2010 and 2011 the total inpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2007, divided by the total paid inpatient hospital days incurred by that hospital in state fiscal year 2007, multiplied by the inpatient hospital days incurred by each hospital during fiscal years 2010 and 2011.

(b) Base (per diem) payments for state fiscal years 2010 and 2011 will not be made to any non state government owned or operated hospital, state owned or

operated or privately owned or operated hospital that was in operation during the hospital's fiscal year ending in 2007 that ceases to operate as a hospital, beginning on the date that the facility ceases to operate as a hospital.

(c) Base (per diem) payments will be interim payments for hospitals that qualify for and file Certified Public Expenditures.

(d) Base (per diem) payments will be reviewed on a quarterly basis to ensure that hospitals are not paid more than the sixteen day reimbursement limit, per beneficiary, except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or who have been referred for treatment as the result of an EPSDT screening. Adjustments will be made to hospitals' interim payments to reflect the results of the reconciliation. Hospitals which are privately owned or operated will be reimbursed on the basis of a maximum sixteen day annual beneficiary limit, subject to a maximum reimbursement equivalent to the current per diem amount multiplied times the covered days (limited to the 16 day annual beneficiary limit).

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: November 10, 1986; August 10, 1987; May 25, 1988, July 12, 1988; May 12, 1989. **Amended**: Emergency Rule effective June 20, 1989. **Amended**: September 13, 1989. **Amended**: Emergency Rule filed and effective September 2, 2010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.04 Inpatient Hospital Access Payments

(1) For the period October 1, 2009, through September 30, 2011, the amount available for inpatient hospital access payments shall be calculated as follows:

(a) The state shall annually identify the total Medicaid inpatient hospital payments for privately operated hospitals for state fiscal year 2007 from all sources except DSH payments.

(b) The state shall estimate the amount that would have been paid for the services identified in step (1) using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.272.

(c) The state shall subtract step (a) from step (b) to determine the aggregate inpatient hospital access payment amount.

(2) For the period October 1, 2009, through September 30, 2011, in addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible private hospital, excluding free-standing psychiatric hospitals, shall receive inpatient

hospital access payments each state fiscal year. Inpatient hospital access payments shall include the following:

(a) An inpatient hospital access payments equal to 121 percent of the difference between the hospital's allowable cost of providing Medicaid inpatient hospital services for state fiscal year 2007 and base payments for the current fiscal year. The access payment will be made contingent upon the assessment tax required by Ala. Code (1975) §40-26B-70, et seq.being collected.

(b) A payment for private hospitals that do not qualify for disproportionate share payments, calculated as follows:

(1) For hospitals with uninsured uncompensated care costs greater than $800,000 in state fiscal year 2007, a payment equal to $400 per Medicaid inpatient day.

(2) For hospitals with uninsured uncompensated care costs less than $800,000 in state fiscal year 2007, a payment equal to $100 per Medicaid inpatient day.

(c) These additional inpatient hospital access payments shall be made on a quarterly basis.

(d) When combined with base payments, inpatient hospital access payments shall not exceed the annual inpatient upper payment limit.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.05 Psychiatric Hospitals

(1) For the period October 1, 2009, through September 30, 2011, in addition to any other funds paid to private free-standing psychiatric hospitals for inpatient hospital services to Medicaid patients, qualifying hospitals shall receive an annual private free-standing psychiatric hospital access payment equal to $185 per Medicaid inpatient day paid in state fiscal year 2007.

(2) For the period October 1, 2009, through September 30, 2011, Medicaid shall pay Bryce Hospital Adolescent Unit a base (per diem) payment based on 2007 inpatient payments divided by 2007 total Medicaid days trended by the hospital market basket index as published by Global Insight Health-Care Cost Review to the current fiscal year.

(3) General - Annual cost report filing, by completing Medicaid prescribed standard cost report forms, is mandatory for psychiatric hospitals. Cost reports shall be completed in accordance with the Instructions for the Alabama Medicaid Uniform Cost Report.

(a) Cost Report Year-Ends - Each provider is required to file a uniform cost report for each fiscal year. The provider may elect the last day of any month as the fiscal year end. The cost report is due ninety (90) days after the fiscal year end elected by the provider. To change the fiscal year end, a written request must be received by the Alabama Medicaid Agency no later than sixty (60) days prior to the close of the provider's current cost reporting period. Providers must have written approval from the Alabama Medicaid Agency before changing the reporting period.

(b) Cost Report Filing - One copy of the complete uniform cost report must be received by Medicaid within three months after the Medicaid cost report year-end. It shall be signed by an authorized official or owner of the hospital. If the cost report is prepared by anyone other than an official or a full-time employee of the hospital, such person shall duly execute and submit the report as the Cost Report Preparer. The signatures of both the hospital official and Cost Report Preparer, if any, must be preceded by the following certification:

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared on behalf of(hospital name(s) and Number(s)) for the cost report period beginning and ending and that to the best of my knowledge and belief, it is a true, correct, and complete report prepared from the books and records of the hospital(s) in accordance with applicable Alabama Medicaid Reimbursement Principles, except as noted.

Signed _____
Officer or Administrator
of Hospital(s)

Cost Report Preparer

By:

Title

Date Date

Any cost report received by Medicaid without the required original signatures and/or certification(s) will be deemed incomplete and returned to the hospital.

A cost report may be submitted in electronic format with a printed signed page of certification.

(c) Extensions - Cost reports shall be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by hospitals. Extensions may be granted only upon approval by Medicaid. The extension request must be in writing, containing the reasons for the request, and must be made prior to the cost report due date. Only one thirty-one day extension per cost reporting year will be granted by the Agency.

(d) Penalties

(1) Late Filing - If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of one hundred dollars per day for each calendar day after the due date. This penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting documentation. A cost report that is over ninety (90) days late may result in termination of the hospital from the Medicaid program. Further, the entire amount paid to the hospital during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The hospital will have thirty (30) days to refund the overpayment or submit the cost report after which Medicaid may institute a suit or other action to collect this overpayment amount. No further payment will be made to the hospital until the cost report has been received by Medicaid.

(2) Reporting Negligence

a. Whenever a provider includes a previously disallowed cost on a subsequent year's cost report, if the cost included is attributable to the same type good or service under substantially the same circumstances as resulted in the previous disallowance, a negligence penalty of up to $10,000 may be assessed at the discretion of the Alabama Medicaid Agency.

b. This penalty shall be in addition to, and shall in no way affect, Medicaid's right to also recover the entire amount of any overpayment caused by the provider's or its representative's negligence.

c. A previously disallowed cost, for the purposes of a negligence penalty assessment, is a cost previously disallowed as the result of a desk review or a field audit of the provider's cost report by Medicaid and such cost has not been reinstated by a voluntary action of Medicaid. The inclusion of such cost on a subsequent cost report by the provider, or its representative, unless the provider is pursuing an administrative or judicial review of such disallowance, will be considered as negligent and subject to the penalty imposed by this Rule.

(4) Calculation of Medicaid Prospective Payment Rates for Inpatient Claims.

(a) Payments for inpatient services shall be based on a prospective per diem rate determined by the Alabama Medicaid Agency.

(b) Rate Setting Period - The as-filed immediately preceding year's cost report will be used to compute a hospital's prospective inpatient per diem rate each year, except for those hospitals on an operating budget or filing an abbreviated cost report, thus the base period is

moving. The cost report shall be desk reviewed and any non-reimbursable items will be removed from reported cost prior to calculating a rate.

(c) Rate Review Period - The per diem rates as calculated by Alabama Medicaid Agency shall be provided to the hospitals prior to the effective date for their information and review.

(d) Per Diem Rate Computation - The total Medicaid cost per diems from the cost report shall be adjusted as follows:

(1) The medical education cost per diem and the capital-related cost per diem are subtracted from the inpatient hospital cost per diem. The remaining cost per diem is separated into Administrative and General (A & G) and non-Administrative and General per diem components. The components will then be multiplied by the applicable hospital industry trend factor (as adjusted by any relevant trend factor variance). The resulting trended A & G cost per diem will be arrayed within hospital grouping in ascending order. The number of psychiatric hospitals will be multiplied by 60% to determine the position of the hospital that represents the 60th percentile. That hospital's cost in each urban grouping will become the ceiling for that grouping. The ceiling or actual cost per day (whichever is less) will be the adjusted A & G per diem cost. Add the adjusted (if applicable) A & G per diem component cost to the non-administrative per diem component cost. Psychiatric hospitals shall be subject to a 60th percentile ceiling.

(2) Capital-Related and Medical Education Costs Per Diem:

a. Adjust capital-related cost for all hospitals per diem by any applicable low occupancy cost per day. b. Medical Education cost per diem will be multiplied by the hospital industry medical education costs trend factor.

(3) The total Medicaid per diem cost per day, subject to the overall 80th percentile ceiling, shall consist of:

a. Operating costs as adjusted in (1) above.

b. Capital-related costs as determined in (2)(b) above.

(4) The total cost per day will be arrayed in ascending order. The number of hospitals will be multiplied by the applicable percentile to determine the position of the hospital that represents the appropriate percentile. That hospital's cost will be the ceiling.

(5) The lesser of the above determined ceiling or actual cost per day shall be added to any applicable education cost. The sum shall be a hospital's Medicaid per diem rate for the new period.

(e) Adjustments to Rates - The prospectively determined individual hospital's reimbursement rate may be adjusted as deemed necessary by the Agency. Circumstances which may warrant an adjustment include, but are not limited, to:

(1) A previously submitted and/or settled cost report that is corrected. If an increase or decrease in rate results, any retroactive adjustments shall be applied as of the effective date of the original rate. Any such payment or recoupment shall be made by a rate change and/or a lump sum adjustment if the adjustment applies to the current rate period, or by a lump sum adjustment, if the adjustment applies to a prior rate period.

(2) The information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the

original rate. This situation may be considered grounds to suspend the hospital from participation in the Alabama Medicaid Program.

(3) The hospital experiences extraordinary circumstances which may include, but are not limited to, an Act of God, war, or civil disturbance. Adjustments to reimbursement rates may be made in these and related circumstances.

(4) Under no circumstances shall adjustments resulting from paragraphs (1) through (3) above exceed the ceiling established. However, if adjustments as specified in (1) through (3) so warrant, Medicaid may recompute ceilings.

(5) Low Occupancy Adjustment - A low occupancy adjustment shall be computed for hospitals which fail to maintain the minimum level of occupancy of the total licensed beds. A 70% occupancy factor will apply to hospitals with 100 or fewer beds. An 80% occupancy factor will apply to hospitals with 101 or more beds. Such adjustment will be composed of the fixed cost associated with the excess unoccupied beds and shall be a reduction to Medicaid inpatient cost. It shall be computed in the manner outlined as follows:

LOW OCCUPANCY ADJUSTMENT FOR HOSPITALS

LOA = (1- TBD) ACC
(Y ABD)

TBD = Total Bed Days Actually Used During the Cost Report Period,

ACC = Allowable Capital Cost

ABD = Available Bed Days Which is Determined by Multiplying the Total Licensed Beds Times the Number of Days in the Cost Report Period

Y = Occupancy Factor
(Y = 70% 100 beds or less
(Y = 80% 101 beds or more

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.06 Disproportionate Share Hospital (DSH) Payments

1) For the period October 1, 2009, through September 30, 2011, Non State Government Owned and Operated Hospitals and State Owned Hospitals which are qualified to, and which do, certify public expenditures claimable for Federal Financial Participation (FFP) in accordance with 42 CFR 433.51(b) will be paid a DSH payment based on the difference between the hospital's reasonable costs incurred in serving Medicaid inpatients, as determined in accordance with Medicare principles outlined in Exhibit C of AL-09-005 Attachment 4.19-A of the Medicaid State Plan, and the interim payments made under paragraph (c)of this Rule.

(2) For the period from October 1, 2009, to September 30, 2011, the Alabama Medicaid Agency shall appropriate and expend the full disproportionate share allotment to hospitals under Section 1923(f)(3) of the Social Security Act (the Act) in a manner consistent with the hospital-specific DSH limits under section 1923(g) of the Act.

(a) Payments to disproportionate share hospitals shall be made to all hospitals qualifying for DSH payments under Section 1923(b) and 1923 (d) of the Act.

(b) Medicaid shall pay qualifying public and state owned disproportionate share hospitals an amount equal to each hospital's allowable uncompensated care cost under the hospital specific DSH limit in Section 1923(g) of the Act during state fiscal year 2007. State owned institutions for mental disease shall receive no more than the same disproportionate share hospital payments the institutions received in state fiscal year 2009.

(c) Qualifying public and state owned disproportionate share hospitals as defined on Exhibit C of AL-09-005 Attachment 4.19-A of the Medicaid State Plan shall receive an amount such that the sum of net inpatient hospital base payments, net outpatient hospital base payments and DSH payments are equal to the greater of 2007 total Medicaid inpatient, outpatient and DSH payments or ninety-five percent of allowable Medicaid costs.

(d) The DSH allotment remaining after DSH payments have been made to public and state owned hospitals shall be paid to private hospitals as defined in Exhibit C of AL-09-005 Attachment 4.19-A of the Medicaid State Plan. DSH payments shall be paid to eligible private hospitals as follows:

(1) A payment equal to 7.93 percent of each hospital's eligible uncompensated care costs in state fiscal year 2007; and

(2) A payment equal to each eligible hospital's pro rata share of the DSH allotment remaining following payment under subsection (a). The payment shall be based upon each hospital's eligible uncompensated care costs under the hospital specific DSH limit in Section 1923(g) of the Act during state fiscal year 2007, divided by the total eligible uncompensated care costs for all eligible private disproportionate share hospitals during state fiscal year 2007.

(e) Total DSH payments to each hospital shall be made during the first

month of the state fiscal year.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.07 Calculation of Medicaid Prospective Payment Inpatient Rate for Out-of-State Hospitals

(1) Payment for inpatient services provided by all out-of-state hospitals shall be the lesser of the submitted covered charges or the Alabama flat rate which shall be composed of the average of the per diem rate paid to out-of-state hospitals in FY 2009 inflated annually by the Global Insight.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.08 Outpatient Services

(1) Outpatient Medicaid Base Payments.

(a) Medicaid shall pay each hospital as a base amount for state fiscal years 2010 and 2011 the total outpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2007, divided by the total outpatient encounters (ICN count) incurred by that hospital in state fiscal year 2007, multiplied by the total outpatient encounters (ICN count) incurred by each hospital during fiscal years 2010 and 2011.

(b) Payment for all out-of-state outpatient hospital services will be from approved rates, by procedure code, as established by Medicaid with any annual/periodic adjustments to the fee schedule being published on the Alabama Medicaid Agency's website (http://www.medicaid.alabama.gov/billing/fee_schedules.aspx?tab=6).

(c) The Medicaid rates were set as of October 1, 2009 and are effective for services on or after that date. Except as otherwise noted in the plan, Medicaid developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Alabama Medicaid Agency's website (http://www.medicaid.alabama.gov/billing/fee_schedules.aspx?tab=6).

(2) Outpatient Access Payments.
For the period from October 1, 2009, through September 30, 2011, in addition to any other funds

paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital, except for hospitals as outlined in 3. below, shall receive outpatient hospital access payments each state fiscal year. The outpatient hospital access payment shall be calculated as follows:

(a) The Medicaid Agency shall identify the total Medicaid outpatient hospital payments to privately operated hospitals for state fiscal year 2007.

(b) The Medicaid Agency shall estimate the amount that would have been paid for the services identified in step (a) using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321.

(1.) The Agency shall subtract step (a) from step (b) to determine the aggregate outpatient hospital access payment amount.

(2.) Each eligible privately owned or operated hospital, excluding private free-standing psychiatric hospitals, shall annually receive outpatient access payments equal to the difference between the hospital's allowable cost of providing Medicaid outpatient hospital services for state fiscal year 2007 and base payments for the current fiscal year.

(c) Outpatient hospital access payments shall be made on a quarterly basis.

(3) Privately owned acute care hospitals, that meet the criteria in (a) and (b) below, shall be paid an enhanced payment not to exceed in the aggregate, the upper payment limit (UPL) as described in 42 CFR 447.321.

(a) The hospital must be located in a county with a population greater than 200,000 (according to the latest U.S. census), and

(b) The hospital must participate in the county's largest city's outpatient/emergency room assistance program. The enhanced payment to privately owned acute care hospitals, that meet the criteria in (a) and (b) above, excluding hospitals which predominately treat children under the age of 18 years, will be determined on an annual basis by Medicaid and divided evenly among qualified hospitals.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.09 MEDICARE CATASTROPHIC COVERAGE ACT DAY AND COST OUTLIERS

(1) Day Outliers - The Alabama Medicaid Agency does not impose durational limits for medically necessary inpatient services provided to children under the age of 6 years in hospitals deemed by the Agency as disproportionate and under the age of 1 in all hospitals. Because we pay for all medically necessary days of care for these children, we meet the day outlier requirement of the Medicare Catastrophic Coverage Act and no additional payments are available.

(2) Cost Outliers

a. A cost outlier for an extremely costly length of stay for a child under age 6 receiving medically necessary services in a hospital deemed by the Alabama Medicaid Agency as disproportionate share and under age 1 in all hospitals, is defined as a claim for payment for a discharged child for allowable services rendered from the date of admission to the date of discharge which meets the following criteria:

b. The Medicaid allowed charges per day for the length of stay for Medicaid eligible children as outlined above must exceed four times the hospital's mean total charge per day as established by Medicaid from Agency paid claim data.

(c). Payment of Cost Outliers

The sum of allowed charges in excess of four times the mean total charge per day shall be multiplied by the hospital's current rate period percent of total Medicaid cost to total Medicaid charges (per Worksheet C of the Medicaid Cost Report) to establish the amount to be paid as a cost outlier. The outlier payment per Medicaid eligible child as outlined above shall be limited to $10,000 per discharge and a total of $50,000 during the per diem rate cycle October 1 through September 30.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.10 The CMS 2552-96 Cost Report

(1) The Alabama Medicaid Agency uses the electronic cost report (ECR) filing of the Form CMS-2552-96 Hospital and Hospital Health Care Complex Cost Report, as defined in CMS Provider Reimbursement Manual (PRM) 15-II along with all accompanying schedules, forms and supporting information (hereinafter referred to as “Form CMS 2552-96)for its Medicaid program and all acute care hospitals must submit this report for fiscal years ending in 2011.

(2) All Medicaid data completed. The due date corresponds with the Medicare intermediary.

(3) Any extension or change to report period must be reported to the Medicaid Provider Audit Division in writing.

(4) Late Filing - If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of one hundred dollars per day for each calendar day after the due date.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.11 Other Matters

(1) The total Medicaid cost per diems can be adjusted if the hospital experiences extraordinary circumstances which may include, but are not limited to, an Act of God, war, or civil disturbance. Adjustments to reimbursement rates may be made in these and related circumstances at the discretion of the Alabama Medicaid Commissioner.

(2) New Hospital Facilities - A new facility shall submit a budget of cost for Medicaid inpatient services for its initial cost reporting period. The Alabama Medicaid Agency will determine a per diem rate from this budget. After the budget period, an actual cost report will be filed for the budgeted period. The Alabama Medicaid Agency will calculate a per diem rate in order to determine if any under or overpayment has been made to the hospital.

(3) In a transfer which constitutes a change of ownership, the old and new providers shall reach an agreement between themselves concerning trade accounts payable, accounts receivable, and bank deposits. Medicaid will pay the new provider for unpaid claims for services rendered both prior to and after the change of ownership. The new provider shall be liable to Medicaid for unpaid amounts due Medicaid from the old provider.

(4) The hospital must "split bill" for inpatient services each year as of December 31. This "split billing" period is necessary for the hospital and the Alabama Medicaid Agency to determine eligibility for services provided each calendar year.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Emergency rule filed and effective September 2, 2010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Chapter 24. End Stage Renal Disease Program

Rule No. 560-X-24-.01. End Stage Renal Disease(ESRD) Services – General.

End Stage Renal Disease (ESRD) services are out-patient maintenance services, which may be provided by a free-standing ESRD facility or a renal dialysis center.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.2102(e). Rule effective October 1, 1982. This amendment effective January 14, 1987.

Rule No. 560-X-24-.02. Participation.

(1) In order to participate in the Title XIX Medicaid Program and to receive Medicaid payment for services, ESRD facilities/centers must meet all the following requirements:

(a) Certification for participation in the Title XVIII Medicare Program

(b) Approval by the appropriate licensing authority

(c) Compliance with Title VI of the Civil Rights Act of 1964 and with Section 504 of the Rehabilitation Act of 1973;

(d) Submission of a letter requesting enrollment; and execution of a contract with the Alabama Medicaid Agency.

(2) Satellites and/or subunits of facilities/centers must be separately approved and execute a contract with Medicaid.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.2102,(e)(2)(3), Section 441.40. Rule effective October 1, 1982. This amendment effective January 14, 1987.

Rule No. 560-X-24-.03. Coverage for Outpatient Maintenance Dialysis.

(1) Maintenance dialysis treatments are covered when they are provided by a Medicaid enrolled ESRD hospital-based renal dialysis center or free-standing ESRD facility. The most common elements of a dialysis treatment are overhead costs, personnel services (administrative services, registered nurse, licensed practical nurse, technician, social worker, dietician), equipment and supplies, use of a dialysis machine and its maintenance, ESRD related laboratory tests, certain injectable drugs such as heparin and its antidote, and biologicals. Reimbursement will be based on a composite rate consisting of these elements.

(2) Hemodialysis is defined as the removal of certain elements from the blood by virtue of the difference in the rates of their diffusion through a semipermeable membrane while the blood is being circulated outside the body. Limited to 156 sessions per year which provides for three sessions per week.

(3) Peritoneal dialysis is defined as a process by which waste products and excess fluids are removed from the blood, but unlike hemodialysis where the blood passes through a machine, peritoneal dialysis is done inside the body. There are two types of peritoneal dialysis that will be covered:

(a) Continuous cycling peritoneal dialysis (CCPD), which requires a machine, and

(b) Continuous ambulatory peritoneal dialysis (CAPD), which does not require a machine. CAPD is a continuous dialysis process that uses the patient's peritoneal membrane as a dialyzer. CCPD and CAPD are furnished on a continuous basis, not in discrete sessions, and will be paid a daily rate, not on a per treatment basis.

Author: Jerri Jackson, RN Analyst, Institutional Services Unit.
Statutory Authority: State Plan;Title XIX, Social Security Act; 42 C.F.R. Section 405.2163.
History: Rule effective October 1, 1982. **Amended:** January 1, 1987; January 14, 1987; August 14, 1991. **Amended:** Filed February 18, 2005; effective May 16, 2005.

Rule No. 560-X-24-.04. Laboratory Services.

Laboratory tests listed below are considered routine and are included as part of the composite rate of reimbursement. All other medically necessary lab tests are considered nonroutine and must be billed directly by the actual provider of service.

(a) Hemodialysis

1. Per treatment - All hematocrit and clotting time tests furnished incidentally to dialysis treatments.
2. Weekly - Prothrombin time for patients on anticoagulant therapy; serum creatinine, BUN.
3. Monthly

Serum Calcium	Serum Biocarbonate
Serum Potassium	Serum Phosphorous
Serum Chloride	Total Protein
Alkaline Phosphatase	LDH
SGOT	

(b) Continuous Ambulatory Peritoneal Dialysis (CAPD) Monthly

BUN	Total Protein
Creatinine	Albumin
Sodium	Alkaline Phosphatose
Potassium	LDH
CO2	SGOT
Calcium	HCT
Magnesium	Hgb
Phosphate	Dialysis Protein

(c) All laboratory testing sites providing services to Medicaid recipients, either directly by provider, or through contract, must be Clinical Laboratory Improvement Amendments (CLIA) certified to provide the level of complexity testing required. Providers are responsible to assure Medicaid that all CLIA regulations are strictly adhered to, both now and as regulations change in the future. Providers are responsible for providing Medicaid waiver certification numbers as applicable.

(d) Laboratories which do not meet CLIA certification standards are not eligible for reimbursement for laboratory services from the Alabama Medicaid Program.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.2163. Rule effective October 1, 1982. This amendment effective January 14, 1987. Effective date of this amendment May 13, 1993.

Rule No. 560-X-24-.05. Ancillary Services

(1) Medically necessary take home drugs must be billed under the pharmacy program by the actual provider of services.

(2) Routine parenteral items are included in the facility composite rate and may not be billed separately.

(3) Nonroutine injectables administered by the facility may be billed by the facility actually providing this service. Nonroutine injectables are defined as those given to ameliorate an acute condition such as arrhythmia or infection.

(4) Routine drugs or injectables administered in conjunction with dialysis procedures are included in the facility's composite rate and shall not be billed separately. These include but are not limited to the following:

Heparin	Blucose
Protamine	Dextrose
Mannitol	Antiarrythmics
Saline	Antihistamines
Pressor drugs	Antihypertensives

(5) The administration fee for injectables is included in the facility's composite rate for dialysis and must not be billed separately under a physician provider number.

(6) Reimbursement for procedures cannot exceed the allowable amount under Medicaid. The following procedures are nonroutine and must be billed by the actual provider of service.

(a) 5-76061- Bone Survey-annually (roent-genographic method or photon absorptrometric procedure for bone mineral analysis)

(b) 5-71020- Chest X-ray-every six months

(c) 6-95900- Nerve Conductor Velocity Test (Peroneal NCV) every three months

(d) 6-93000- EKG - every three months

Authority: State Plan, 4.19-E; Title XIX, Social Security Act; 42 C.F.R. Section 416.61, 416.65 and 416.120. Rule effective October 1, 1982. Amended January 14, 1987 and August 10, 1987. Effective date of this amendment November 15, 1989.

Rule No. 560-X-24-.06. Reserved.

Rule No. 560-X-24-.07. Physician Services.

(1) All physician services rendered to each outpatient maintenance dialysis patient (regardless of the patient's mode of or setting for dialysis) shall be billed on a monthly capitation basis.

(2) Services not covered by the monthly capitation payment MCP) and which are reimbursed in accordance with usual and customary charge rules are limited to:

(a) Declotting of shunts

(b) Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these services.

(c) Nonrenal related physician services. These services may be furnished either by the physician providing renal care or by another physician. They may not be incidental to services furnished during a dialysis session, or office visit necessitated by the renal condition.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 405.542 (c), and Federal Register (July 2, 1986). Rule effective October 1, 1982. This amendment effective January 14, 1987.
Rule No. 560-X-24-.08. Medicare Deductible and Coinsurance.

Payment for renal dialysis crossover claims shall be made on the basis of a ratio of costs to charges as developed by Medicaid.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.300. Rule effective October 1, 1982. This amendment effective January 14, 1987.

Rule No. 560-X-24-.08. Billing and Sending Statement to Eligible Alabama Medicaid Recipients.

(1) No eligible Alabama Medicaid recipient is to receive a bill or statement for covered services or items, once that recipient has been accepted as a Medicaid patient.

(2) The provider may send a notice to the recipient stating their claim is still outstanding, provided the notice indicates in bold letters, "THIS IS NOT A BILL."

(3) It is the responsibility of the provider to follow up with the fiscal agent and/or Medicaid, and not the recipient, on any problem or unpaid claim.

(4) The recipient is not responsible for the difference of covered charges billed and amount paid by Medicaid for covered charges.

(5) Provider may bill eligible recipients for noncovered services.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.15, Section 447.50, Section 447.55; Rule effective July 9, 1984. This amendment effective January 14, 1987.

Chapter 25. Medicaid Eligibility.

Rule No. 560-X-25-.01. Governing Authorities.

(1) In determining eligibility for Medicaid, the Agency's rules and regulations are governed by the Social Security Act (hereinafter referred to as the Act), Titles XVI and XIX; 20 C.F.R. (Part 416); 42 C.F.R. (Part 435); and the Alabama State Plan for Medical Assistance.

(2) Any part of the Code of Federal Regulations cited herein is adopted by reference as a part of the Rule in which it is cited.

Authority: Code of Alabama, Section 41-22-9.

Rule No. 560-X-25-.02. Administrative Responsibilities.

(1) The Alabama Medicaid Agency determines eligibility for individuals for the following programs:

(a) All Medicaid programs in accordance with Title XIX of the Act except those listed in (2) and (3) below; and,

(b) Low Income Subsidy (LIS) under Medicare Part D in accordance with the rules under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

(2) The Social Security Administration determines the eligibility of individuals for Supplemental Security Income under Title XVI of the Act.

(3) The Alabama Department of Human Resources determines Medicaid eligibility of individuals qualifying for various forms of assistance in accordance with Titles IV-A, IV-E, and XIX of the Act.

Author: Audrey Middleton, Associate Director, Policy and Program Implementation Unit, Certification Support Division.
Statutory Authority: Social Security Act, Titles XVI and XIX; and Sections 1860D-14, 1902(a)(66), 1905(p)(3), and 1935(a); 20 CFR 416, 42 CFR 423.774, 423.904, and 42 CFR 435; and the State Plan.
History: Rule effective October 1, 1982. **Amended:** Filed November 18, 2005; effective February 15, 2006.

Rule No. 560-X-25-.03. Coverage Groups.

(1) The following are the general groups of individuals designated as categorically eligible under the State Plan for Medical Assistance, and who as a result are Medicaid eligible:

(a) Aged, blind or disabled persons who receive Supplemental Security Income (SSI) under Title XVI;

(b) Persons who are residents of Title XIX institutions but who are not eligible for SSI, Optional Supplementation or AFDC because their income exceeds $50 per month but is not more than 300 percent of the current SSI benefit amount payable to an individual in his own home who has no income~~.~~;

(c) Persons who would be eligible for SSI or Optional Supplementation but for the fact that they are residents of a Title XIX institution;

(d) All aged, blind and disabled persons who were residents of a Title XIX institution as of December 31, 1973, and who were converted from the former State program (OAP, APTD, AB). If ineligible under current eligibility rules these individuals are entitled to use the rules for determining eligibility which were in effect under the State's Plan for Medical Assistance in December 1973;

(e) Persons who:

1. are currently receiving Old Age Survivors Disability Insurance (OASDI);
2. are ineligible for SSI due to income;
3. were contemporaneously eligible for both OASDI and SSI in the same month after April 1977; and
4. would be eligible for SSI but for OASDI cost-of-living increases received since the last month of contemporaneous OASDI and SSI eligibility~~.~~;

(f) Individuals receiving mandatory or optional State Supplementation payments;

(g) Individuals who would be eligible for SSI, except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972 or who were eligible for such cash assistance but for the fact that they were residents of a medical institution or intermediate care facility;

(h) Medicaid for Low Income Families: Individuals eligible for Medicaid through the Medicaid for Low Income Families Program or who meet the eligibility criteria for Medicaid for Low Income Families based on policies in effect for the AFDC program as it existed on July 16, 1996, based on Section 1931 of the Social Security Act.

The following individuals are deemed to be eligible for Medicaid for Low Income Families:

1. AFDC qualified pregnant women whose family income and resources fall within the standards for Medicaid for Low Income Families.
2. Individuals under age 18 who would qualify for Medicaid for Low Income Families but do not qualify as dependent children, since they are children for whom public agencies have assumed full or partial financial responsibility and who are in foster homes or private institutions.

(i) All individuals receiving assistance under Title IV-E of the Act, including children for whom adoption assistance or foster care payments are made in Alabama or out of state;

(j) Individuals who are eligible for Medicaid solely because they require and receive services under CMS approved home and community based services waiver. See Appendix C of the waiver document for a complete description of eligibility groups served by a specific waiver.

(2) Section 1902 (e)(4) of the Social Security Act as amended by the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3, Section 113) mandates that a child born to a woman eligible for and receiving Medicaid on the date of the child's birth be deemed eligible for Medicaid for a period of one year. Under Section 211 of Public Law 111-3, children who are initially eligible for Medicaid as deemed newborns are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States and may not be required to provide further documentation of citizenship or identity at any subsequent Medicaid eligibility determination or redetermination.

(3) The following coverage is mandated by the Consolidated Omnibus Budget Reconciliation Act, Section 9501 of Public Law 99-272.

(a) All pregnant women who otherwise meet Medicaid for Low Income Families income and resource criteria.

(b) Sixty-day postpartum coverage to women who were eligible for and receiving Medicaid on the date the pregnancy ended.

(4) The following coverage is mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985, Section 12202 of Public Law 99-272. Coverage is extended to disabled widows or widowers if he or she meets all of the following criteria:

(a) was entitled to a monthly insurance benefit for December 1983 under Title II of the Social Security Act;

(b) was entitled to and received a widow's or widower's benefit for January 1984 based on a disability under Section 202(e) or (f) of the Social Security Act;

(c) became ineligible for SSI/SUP in the first month in which that increase was paid to him or her (and in which a retroactive payment of that increase for prior months was not made) because of the increase in the amount of the widow's or widower's benefit which resulted from the elimination of the reduction factor for disabled widows and widowers entitled before age 60;

(d) has been continuously entitled to a widow's or widower's benefit under Section 202(e) or (f) of the Act from the first month that increase in the widow's or widower's benefit was received;

(e) would be eligible for SSI/SUP benefits if the amount of that increase, and any subsequent cost-of-living adjustments in widow's or widower's benefits provided under Section 215(i) of the Act, were disregarded; and

(f) makes written application for benefits under this provision before July 1, 1988.

(5) The following coverage is mandated by Section 1634(c) of the Social Security Act as amended by Section 6, P.L. 99-643. Individuals who lose eligibility for SSI because of entitlement to, or an increase in Social Security benefits received as a Disabled Adult Child (DAC) shall continue to be eligible for Medicaid if they meet the following criteria:

(a) meet current SSI income and resource limits after a disregard of the entitlement to, or an increase in Social Security benefits.

(b) makes written application for continuation of Medicaid coverage no later than 30 days after notification of possible eligibility by the Medicaid Agency.

(6) The following coverage is provided by state option under the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509):

(a) All pregnant women with a family unit income, as defined by Title IV-A criteria, not in excess of 100 percent of the current federal poverty line;

(b) Pregnant women eligible for Medicaid will continue eligible for prenatal, delivery, and postpartum care, without regard to changes in income, to the end of the 60-day postpartum period;

(c) Infants eligible under SOBRA will be Medicaid eligible up to one year of age while residing in a family unit whose income does not exceed 100 percent of the current federal poverty line.

(7) The following coverage is mandated by the Omnibus Budget Reconciliation Act of 1987, (P.L. 100-203, Section 9116). Disabled widows and widowers may be eligible for and able to retain Medicaid benefits if they meet all of the following criteria:

(a) have reached 60 but not age 65;

(b) not eligible for Part A Medicare;

(c) eligible for and receiving Title II benefits (OASDI); and,

(d) lost SSI as a result of receiving early widows/widowers benefits.

(8) The following coverage is mandated by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360, Section 301) as amended by P.L. 101-508. This limited coverage is described in the State Plan for Medical Assistance. Individuals may be eligible for Catastrophic Coverage as Qualified Medicaid Beneficiaries alone or may be dually eligible if they meet the criteria of the other categorical eligibility as described in this Chapter. Aged, blind, or disabled individuals may be eligible under these provisions if they meet the following criteria:

(a) Entitled to Part A Medicare.

(b) Have resources that do not exceed three times the resource standard for a recipient of Supplemental Security Income. Resource standards are a federal requirement, but are not an eligibility requirement for Alabama's program.

(c) Have income at or below the following limits:

Income for 1989 will be 85% of federal poverty level.
Income for 1990 will be 90% of federal poverty level.
Income for 1991 will be 100% of federal poverty level.
Income for 1992 and afterwards will be 100% of federal poverty level.

(9) Section 4501(b) of the Omnibus Budget Reconciliation Act of 1990 amended 1902(a)(10)(E) of the Social Security Act to mandate coverage of Specified Low Income Medicare Beneficiaries beginning January 1, 1993. This provision requires medical assistance payment of Medicare Part B premiums for eligible individuals. The Specified Low Income Medicare Beneficiaries (SLMBs) must meet all of the eligibility requirements for Qualified

Medicare Beneficiary (QMB) status with the exception of income limits. The SLMBs must have income within the limits listed below:

Income for 1993 cannot be less than 100% and not more than 110% of federal poverty level.

Income for 1994 cannot be less than 100% and not more than 110% of federal poverty level.

Income for 1995 and afterwards cannot be less than 100% and not more than 120% of federal poverty level.

The SLMBs must have resources that do not exceed three times the resource standard for a recipient of Supplemental Security Income. Resource standards are a federal requirement, but are not an eligibility requirement for Alabama's program.

(10) The following coverage is mandated by the Balanced Budget Act of 1997 (Public Law 105-33, Section 4732). Qualifying Individuals (QI-1).

(a) Individuals who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);

(b) Whose income exceeds 120 percent of the federal poverty level but does not exceed 135 percent of the federal poverty level;

(c) Whose resources do not exceed three times the maximum resource standard under SSI; Resource standards are a federal requirement, but are not an eligibility requirement for Alabama's program.

(d) Who is not eligible for any other Medicaid program; and,

(e) Who has been awarded benefits when federal funds are available for the program. Eligibility is awarded on a first-come, first-served basis.

(Medical assistance for the above group is limited to payment of the Medicare Part B premiums under Section 1839 of the Act.)

(11) The following coverage is mandated by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) Section 6401 of P.L. 101-239).

(a) All pregnant women with a family unit income, as defined by Title IV-A criteria, not in excess of 133 percent of the current federal poverty level;

(b) Pregnant women eligible for Medicaid under this provision will continue eligible for prenatal, delivery, family planning, and postpartum care, without regard to changes in income, to the end of the month in which the 60th day of the postpartum period falls; and

(c) Children under age 6 with a family unit income, as defined by Title IV-A criteria, not in excess of 133 percent of the current federal poverty level.

(12) Children under 21, who would be eligible for Medicaid for Low Income Families, ACFC, SSI or otherwise Medicaid eligible if they were in their own home, but who are admitted as inpatients of a psychiatric facility.

(13) Qualified Disabled and Working Individual - A Qualified Disabled and Working Individual is an individual:

(a) under age 65;

(b) who has been entitled to Title II Disability Insurance Benefits (DIB);

(c) whose DIB ended due to earnings exceeding the Substantial Gainful Activity (SGA) level;

(d) who continues to have the same disabling physical or mental condition and not expected to improve;

(e) not otherwise entitled to Medicare;

(f) entitled to enroll in Medicare Part A under the provisions of 6012 (i.e., DIB terminated because of work, still working) and

(g) whose income, based on SSI rules, is under 200% of the Federal Poverty Level (FPL);

(h) whose resources, based on SSI rules, do not exceed twice the SSI resource limit;

(i) who is not otherwise eligible for medical assistance under Title XIX.

(14) The following coverage is mandated by Section 5103 of P.L. 101-508, the Omnibus Budget Reconciliation Act of 1990, (OBRA '90) and is applicable to disabled widows/ widowers and disabled surviving divorced spouses.

Effective January 1, 1991, individuals who lose SSI because of receipt of a Title II benefit resulting from the change in the definition of disability will be deemed to be receiving SSI if:

(a) They were receiving SSI for the month prior to the month they began receiving the Title II benefit;

(b) They would continue to be eligible for SSI if the amount of the Title II benefit were not counted as income; and

(c) They are not entitled to Medicare Part A.

(15) The following coverage is mandated by Section 4601 of P.L. 101-508, the Omnibus Budget Reconciliation Act of 1990 and is effective July 1, 1991. This provision requires a year by year phase in of children born after September 30, 1983 and is applicable to children who:

(a) Have attained age six;

(b) Are under nineteen years of age; and

(c) Have family incomes below 100% of the federal poverty level.

(16) Children who are Medicaid eligible as determined by the State Department of Human Resources, receive state adoption subsidies and have a special need for medical or rehabilitative care.

(17) The following coverage is mandated by the Balanced Budget Act of 1997 (Public Law 105-33, Section 4913). Grandfathered children. Children who were receiving Supplemental Security Income (SSI) as of August 22, 1996 and who were terminated from SSI due to the change in definition of disability by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. These children will remain eligible for Medicaid as long as they continue to meet the eligibility requirements of SSI but for the change in definition of disability

(18) Emergency services, as defined by the Alabama Medicaid Agency, will be covered for illegal aliens who would be otherwise eligible for Medicaid except for enumeration, citizenship and alienage requirements.

(19) The following coverage is allowed by PL 106-354, the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000. Medicaid coverage is available to women who:

(a) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

(b) are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;

(c) are not eligible for Medicaid under any mandatory categorically needy eligibility group;

(d) meet Medicaid citizenship and alienage status; and,

(e) have not attained age 65.

(20) The Plan First waiver extends Medicaid eligibility for family planning services to all women of childbearing age 19 through 55 (who do not have creditable health insurance coverage as defined by the Health Insurance Portability and Accountability Act (HIPAA) and have not had a sterilization procedure performed) with incomes at or below 133% of the federal poverty level that would not otherwise qualify for Medicaid.

Author: Anita Charles, Associate Director, Policy and Program Implementation, Certification Support Division.

Statutory Authority: Social Security Act, Titles XVI and XIX; 20 C.F.R. Part 416; 42 C.F.R. Part 435; Section 2361 and 2362 of the Deficit Reduction Act of 1984; the State Plan for Medical Assistance, Attachment 2.2A; Section 9501, Public Law 99-272 and Section 1905(n)(1)(c) and 1902(e)(5) of the Social Security Act, and Section 12202 of the Consolidated Omnibus Budget Reconciliation Act of 1985; Social Security Act Section 1634(c), P.L. 99-643 and 99-509, and the SSI Improvement Act of 1986; Public Law 100-203, Section 9108, 9116, and 9119; and the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360, Section 301). Omnibus Budget Reconciliation Act of 1989 Section 6401 of P.L. 101-239. Section 6408(d) of OBRA 89. 42 CFR 435.231 and Section 1611(b)(1). Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), Sections 4501, 4603, 5103 and 4601. P. L. 99-272, Section 9529. Section 1915(C) and Section 1902(a)(10)(A)(ii)(VI). Section 4501(b) of OBRA '90 and 42 CFR 435.222. Section 1903(v) of the Social Security Act. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (PL 106-354).

History: Rule effective October 1, 1982. Amended July 1, 1985, July 9, 1985, July 19, 1985, October 9, 1985, July 1, 1986, September 8, 1986; February 9, 1987; June 10, 1987, August 10, 1987, January 8, 1988, April 12, 1988, July 1, 1988, July 12, 1988, September 9, 1988, October 1, 1988, January 10, 1989, January 1, 1989, April 14, 1989, April 2, 1990, July 14, 1990, June 1, 1990, September 13, 1990, October 9, 1990, January15, 1991, January 9, 1991, April 17, 1991, July 13, 1991, October 12, 1991, June 12, 1992, November 12, 1992, January 13, 1993, March

13, 1993, July 13, 1993, May 1, 1993, August 12, 1993, February 1, 1998, February 26, 1998, April 13, 1998, and September 9, 1998. **Amended**: Filed February 16, 1999; effective April 1, 1999. **Amended**: Filed June 19, 2001; effective September 14, 2001. **Amended**: Filed November 19, 2003; effective February 13, 2004. **Amended:** Emergency Rule filed and effective October 14, 2008. **Amended**: Filed October 20, 2008; effective January 16, 2009. **Amended:** Filed April 20, 2010; effective July 16, 2010.

Rule No. 560-X-25-.04. Application, Initial Determination or Denial of Eligibility, and Redetermination of Eligibility.

(1) An application is a specific written request on the designated agency application form which has been completed, dated and signed (including State acceptable electronic signatures) by the applicant and/or applicant's representative or guardian to have eligibility for categorical assistance determined. Application is required before an individual may be determined eligible for Medicaid benefits.

(2) Any person completing an application for Medicaid benefits on behalf of another must have written authority to do so. If the person being represented is unable to sign an authorization, it must be signed by his or her legal guardian, if there is one, or if there is none, then by his or her sponsor. A form entitled, "Appointment of Representative," available from the Alabama Medicaid Agency must be completed and signed by the applicant's representative. A copy of the form is in Rule 560-X-28-.01(16) of this code.

(3) A determination of eligibility is the process by which the Medicaid Agency's worker obtains the facts of the situation of the individual applying for Medicaid or Low Income Subsidy (LIS) as related to each factor of eligibility. In the eligibility determination process, all facts and information related to eligibility which are alleged by the applicant must be substantiated, verified, and documented.

(4) A redetermination of eligibility must be made by the Medicaid Agency, the Department of Human Resources, or the Social Security Administration for every Medicaid or LIS recipient at least once every twelve months. More frequent redeterminations are necessary for recipients whose circumstances are likely to change or from whom information indicates conditions have changed.

(5) When an applicant/recipient fails or refuses to provide needed information within his/her capacity, he/she may be denied or terminated from Medicaid or LIS; because eligibility cannot be determined or redetermined.

(6) Submission of an application for benefits containing a material misstatement, a material omission, or a material false statement shall result in a denial or termination of eligibility, as appropriate, under such application of reapplication.

(7) Any Medicaid eligible child under age 19 who has been correctly determined Medicaid eligible is deemed to be eligible for a total of 12 months regardless of changes in

circumstances other than attainment of the maximum age stated above, as long as the child remains a resident of Alabama.

Author: Audrey Middleton, Associate Director, Policy and Program Implementation Unit, Certification Support Division.
Statutory Authority: Social Security Act, Titles XVI and XIX; Sections 1935(a), 1902(a)(66), 1860D-14, and 1905(p)(3); 20 CFR 416; 42 CFR 423.774; 423.904; and 435.
History: Rule effective October 1, 1982. **Amended** April 15, 1983, July 9, 1985, January 8, 1986, January 14, 1987, April 1, 1998, and September 9, 1998. **Amended:** Filed November 18, 2005; effective February 15, 2006. **Amended:** Filed January 21, 2008; effective April 17, 2008.

Rule No. 560-X-25-.05. General Categorical Eligibility Criteria.

(1) In order to qualify for Medicaid, AFDC-related individuals must meet the non-financial eligibility criteria of the AFDC programs. SSI-related individuals must meet general categorical criteria of age, disability or blindness, residence, and citizenship for the appropriate coverage groups:

(a) Age Requirement - To be eligible, the individual must be 65 years of age or older. This factor is based on SSI policy and must be verified based on evidence requirements stated in SSI policy.

(b) Disability - If under age 65, an individual must be blind or disabled. Disability is defined as the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment(s) which can be expected to last for a continuous period of not less than 12 months.

(c) Blindness - An individual meets blindness criteria when his central vision acuity is 20-200 or less (even with glasses) or a limited visual field of 20 degrees or less in the better eye. A person determined to be blind for purposes of SSI benefits also qualifies as blind for purposes of Medicaid.

(d) Citizenship - To be eligible for Medicaid, a person must be a citizen of the United States, or, if an alien, must be a qualified alien. For qualified aliens arriving before 8/22/1996, they must be a lawful permanent resident, American Indian born in Canada, refugee, asylee, Cuban/Haitian entrant, battered immigrant, Amerasian, person whose deportation has been withheld, honorably discharged veteran, active duty U.S. military, person granted parole for 1 year by INS, or person granted conditional entry under 203 of the immigration law in effect before 4/1/1980. For qualified aliens arriving on or after 8/22/1996, they must be a refugee, asylee, person whose deportation has been withheld, Cuban/Haitian entrant (proceeding groups are eligible for 7 years from date of entry), honorably discharged veteran, active duty U. S. military, Amerasian (eligible for 5 years from date of entry) or lawful permanent resident in U. S. at least 5 years. Aliens should have records to establish naturalization or lawful admission. Non-qualifying aliens are eligible only for emergency services for treatment of emergency medical conditions.

(e) State Resident - A person must be a resident of Alabama during the period covered by application, must indicate intent to remain, and must be capable of indicating such intent.

(f) Interstate Residency Agreements - The only time the above residency rule is not applicable is where the state has entered into a residence agreement with another state. Where this occurs, the state where the person physically resides is his residence for Medicaid purposes. A list of states with which Alabama has entered into residency agreements may be obtained from the Alabama Medicaid Agency.

(g) Eligibility for Other Benefits - An individual is required to apply for any payments or benefits from other sources for which he may be eligible. If an individual is already receiving or is entitled to receive benefits from other sources which are in excess of agency standards or is receiving benefits under a VA contract, the individual is not eligible for Medicaid benefits.

(h) Assignment of Third Party Payments - To be eligible for Medicaid, an individual must assign all third party benefits to the State. Third Party benefits are any benefits for which an entity is or may be liable to pay all or part of the medical cost of an applicant or recipient.

(i) Eligibility for Medicaid benefits ends with the month in which the individual dies.

(j) Social Security Account Number - An individual is required to furnish his Social Security Account Number or verification that he has made application for one.

Author: Shawna White, Policy Research Specialist, Policy and Program Implementation, Certification Support Division
Statutory Authority: Social Security Act, Titles XVI & XIX; 42 C.F.R., Section 401, et seq.; 20 C.F.R. Section 401, et seq.; State Plan.
History: Rule effective October 1, l982. Amended March l5, l983, September 8, 1983, July 9, 1985, and September 9, 1997. **Amended**: Filed September 21, 2001; effective December 14, 2001. **Amended**: Filed July 19, 2002; effective October 16, 2002. **Amended:** Filed August 21, 2003; effective November 14, 2003.

Rule No. 560-X-25-.06 Financial Eligibility Criteria - Resources.

(1) General - In order for an AFDC-related individual to be eligible for Medicaid, he or she must meet the AFDC financial criteria in effect in 1996. An SSI-related individual or couple must not have total countable resources in excess of $2,000 for an individual or $3,000 for a couple. An individual covered under the Qualified Medicare Beneficiary Program created by the Medicare Catastrophic Coverage Act of 1988, the Specified Low Income Medicare Beneficiary Program created by the Omnibus Budget Reconciliation Act of 1990, or the Qualifying Individual Programs created by the Balanced Budget Act of 1997 must not have total countable resources in excess of three times the SSI resource limit. Resource standards for Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries and Qualifying Individuals are a federal requirement but are not an eligibility requirement for Alabama's Medicare Savings Programs.

(a) Liquid vs. Non-liquid Resources. Resources are those assets including both real and personal property which an individual or couple possesses. It includes all liquid (spendable) assets, as well as non-liquid assets. Non-liquid resources are assets which are neither cash nor financial instruments. They are resources which cannot be converted to cash within 20 days.

(b) Income vs. Resources. Income is anything of value an individual/couple receives during a month. Resources are the assets such as those described above, which the individual/couple already has at the beginning of a month in which eligibility for Medicaid is being determined. An item cannot be counted as both income and a resource in the same month.

(2) Minimum exclusions of Non-liquid Resources - The following types of assets may be excluded from countable resources under certain conditions:

(a) Motor vehicles. An automobile may be excluded to the extent that its value does not exceed the amount specified in 20 CFR §416.1218.

(b) Life insurance. Life insurance owned by an individual (and spouse, if any) may be excluded to the extent provided in 20 CFR §4l6.1230.

(c) Household Goods and Personal Effects. Household goods and personal effects are totally excluded from countable resources.

(d) Burial Funds and Burial Spaces.

1. Burial Funds. In determining the resources of an individual (and spouse, if any) there shall be excluded an amount not in excess of $1500 each of funds designated for burial arrangements of the individual or individual's spouse and which are to be used for no other purpose. The applicant/recipient must submit documented evidence of the specific designation of burial funds. Each person's $1500 exclusion must be reduced by:

(i) the face value of insurance policies on the life of an individual owned by the individual or spouse if the face value is $1500 or less and the cash surrender value of those policies has been excluded from the countable resource limit and

(ii) amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial expense.

2. Burial spaces. In determining the resources of an individual, the value of burial spaces for the individual, the individual's spouse, or any member of the individual's immediate family will be excluded from resources. The opening and closing of the grave and headstones are considered as burial space items.

(e) Real Property.

1. Home. If the home is the individual's principal place of residence, and if the individual's or his representative's signed statement identifies the reason for being away from home and the intent to return to the home, it will be excluded as a resource. If an eligible or ineligible spouse resides in what was the individual's principal place of residence prior to institutionalization, it will be excluded as long as the spouse continues to live there. Individuals whose equity interest in the home exceed $500,000 are ineligible for Medicaid long-term care services unless the individual’s spouse, child under 21, or child who is blind or permanently and totally disabled resides in the home.

2. The home may be excluded if a dependent relative is living in the home. (For this purpose a relative is defined as: son, daughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, grandmother, grandfather, grandson, granddaughter, aunt, uncle, sister, brother, stepsister, stepbrother, half-sister, half-brother, niece, nephew, cousin.) Dependency may be of any kind; e.g., financial, medical, etc. If a relative, other than a spouse, is living in the home and is not dependent upon the claimant, he or she is not a dependent relative, then the home cannot be excluded on this basis. The dependency must have been immediately

prior to the applicant's admission to the nursing home, and the dependent's situation must be checked periodically to determine if the dependency continues to exist.

3. Jointly-Owned Home Property. Jointly-owned home property will be excluded from resources if the sale would cause the other owner undue hardship due to the loss of housing. Undue hardship is defined as when; the property serves as the principal place of residence for one of the owners; the sale of the property would result in the loss of that residence; and no other housing would be readily available for the other owner.

4. Income-Producing Property. Income-producing property is excluded from resources when the equity in the property does not exceed $6,000 and the property produces net annual return of at least 6 percent of equity.

(i) Where the value of the property is in excess of $6,000, the amount in excess can be counted toward the resource limitation as long as the individual remains eligible and the property nets at least 6 percent of its equity value per anum.

(ii) Where the property is not excluded because the net annual return is less than 6 percent of the equity value, the total value is an includable resource.

(iii) Where the home is associated with self-support activities, the value of the home, contiguous land, and buildings on the land will be excluded. Total equity in other assets used for producing income must be $6,000 or less and the activity must produce at least 6 percent on the equity. Where the equity value of assets for producing income is in excess of $6,000, the amount in excess will be applied to the resource limitation. Resources used to produce items only for home consumption or tools required by employer are assumed to be netting reasonable rate of return. Property does not have to be utilized if it, in combination with other resources, does not exceed the liquid resource limit.

5. Bona Fide Effort to Sell Interest in Real Property: Real property may be excluded as long as a bona fide effort is being made to sell the property. A bona fide effort to sell is defined as an attempt to sell through listing with a real estate agent or by attempt to sell by the owner. A period in excess of 7 days during which no attempt is made to sell voids this exclusion. To qualify for this exclusion, the property must have been listed for sale as of the first moment of the month that eligibility is being sought. Applicant must agree to reimburse the Agency for expenses incurred during the effort to sell and make prompt repayment after sale. Bona fide effort to sell will be reviewed periodically to verify a continuing effort.

6. Property that is specifically designated for a Plan of Self-Support for the Blind or Disabled, as provided in 20 C.F.R. (Part 416), may be excluded.

(3) Valuation of Resources - The value of an individual's resources for Medicaid eligibility purposes is based upon the individual's equity interest in the resource. Equity is defined as the current market value (or fair market value) of the resource less any recorded indebtedness against the resource, such as a mortgage or lien. A lien taken by the Medicaid Agency under the provisions of 42 U.S.C §1396p and Chapter 33 of this Code does not operate to reduce the current market value of the property until such lien becomes enforceable in accordance with the terms of the above-cited authorities.

(a) In the case of real property, the current market value of the property, for Medicaid eligibility purposes, is the appraised value of the property established by the current tax assessment notice from the tax assessor's office in the county in which the property is located.

1. This appraised value will be used unless the tax assessment:

(i) Is more than one year old;
(ii) Is a special purpose assessment;
(iii) Is under appeal;
(iv) Is based on a fixed rate per acre method;
(v) Does not provide an appraised value or an assessment ratio for determining such value;

2. Only if one of the above conditions exists, other evidence, such as appraisals or estimated from knowledgeable sources, may be used to establish current market value.

(b) In the case of a life estate or remainder interest in real property, the value of the individual's interest is determined by first establishing the current market value of the property and then multiplying that value by the appropriate life estate or remainder factor, based upon the age of the individual, set forth in the Life Estate and Remainder Tables, 26 C.F.R. §20.2031.7.

1. The value obtained shall be presumed correct unless the individual furnishes clear and convincing evidence establishing a lower value. Such evidence includes, but is not limited to:

(i) efforts to sell the property interest, as evidenced by such factors as the price at which the property interest is offered for sale, marketing and advertising exposure given and offers and negotiations;
(ii) appraisals of the property interest by knowledgeable and experienced sources;
(iii) extent and results of negotiations with owners of other interests in the property or owners of adjoining property.

(c) In the case of entrance fees in a continuing care retirement community or life care community the value of the entrance fee shall be considered a resource available to the individual to the extent that:

1. The individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used to pay for care should other resources or income of the individual be insufficient to pay for such care;
2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and
3. The entrance fee does not confer an ownership interest in the continuing care community or life care community.

(4) The following are more liberal resource requirements than SSI for determining the eligibility of individuals as Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries, and Qualifying Individual-1:

(a) All resources of the applicant and the resources of the applicant's spouse are excluded.
(b) All interest and dividend income is excluded.

(5) The following are more liberal resource requirements than SSI for determining the eligibility of individuals eligible under the institutional Medicaid program:

(a) The required net annual income of six percent is waived for the excluded $6,000.00 in equity value for income-producing property essential to self-support.

(b) The consideration of a life estate interest in real property is waived.

(c) Cash value of life insurance policies with combined face value less than $5,000.00 is excluded.

(d) The burial fund exclusion is increased to $5,000.00

(e) Commingling of burial funds is allowed.

(f) Long-Term Care Insurance Policies issued before March 1, 2009

1. Medicaid will not consider resources of a person equal to the amount of long-term care insurance benefit payments in determining Medicaid eligibility when the long-term care insurance policy has paid at least the first three years of nursing home care and/or home health care services.

2. The exclusion shall be for the life of the purchaser provided he or she maintains obligations pursuant to the long-term care insurance policy.

3. Insurance benefit payments made on behalf of a claimant, for payment of long-term care services, shall be considered to be expenditure of resources as required for eligibility for medical assistance to the extent that the payments are all of the following:

(i) For services Medicaid approves or covers for its recipients.

(ii) In an amount not in excess of the charges of the health services provider.

(iii) For nursing home care and/or home health care services.

(iv) For services delivered after October 1, 1997.

(g) Long-Term Care Insurance Policies issued on or after March 1, 2009

1. Medicaid will not consider resources equal to the amount of benefits paid (dollar-for-dollar) by an Alabama Long-Term Care Insurance Partnership Policy (Partnership Policy) for long-term care services received in determining Medicaid eligibility and in estate recovery.

2. The amount to be excluded will be above and beyond the standard resource exclusion provided under the Medicaid State Plan. To qualify for this exclusion, the individual must be covered by a Partnership Policy that has been certified by the Alabama Department of Insurance as meeting the following criteria:

(i) The policy covers a person who was a resident of Alabama when coverage first became effective under the policy. Medicaid will provide reciprocity with respect to long-term care insurance policies covered under other state long-term care insurance partnerships. The amount of the resource exclusion will equal the resource exclusion that would apply to a Partnership Policy issued under the Alabama Long-Term Care Partnership Program.

(ii) The policy meets the definition of a “qualified long-term care insurance policy” found in section 7702B(b) of the Internal Revenue Code of 1986.

(iii) The policy meets the specific requirements of the Deficit Reduction Act of 2005 and National Association of Insurance Commissioners (NAIC) Long Term Care Insurance Model Regulations and Model Act, as last amended.

(iv) The policy includes the following inflation protection: for purchasers under 61 years old, compound annual inflation protection; for purchasers 61 to 76 years old, some inflation protection; and for purchasers 76 years or older, inflation protection may be offered but is not required.

3. The issue date is the effective date of coverage under the policy. If a long-term care insurance policy issued before March 1, 2009 is exchanged after that date for a Partnership Policy, the resource exclusion will apply only with respect to insurance benefits received under the new Partnership Policy.

Author: Anita Charles, Associate Director, Certification Support Division
Statutory Authority: Social Security Act, Titles XVI and XIX; §1902(r)(2); State Plan Attachment 2.6-A; Public Law 100-203, Section 9103; and the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360, Section 301); 20 CFR §416.1212 and §416.1218; 26 CFR §20.2031.7; and 42 CFR §401, et seq., and Deficit Reduction Act of 2005 (P.L. 109-171).
History: Rule effective October 1, 1982, March 15, 1983, May 15, 1983, September 8, 1983, September 8, 1984, March 11, 1985, September 1, 1985, December 7, 1985, April 11, 1986, August 11, 1986, August 10, 1987, January 1, 1988, February 9, 1988, August 1, 1988, November 10, 1988, January 1, 1989, April 14, 1989, July 13, 1991, January 14, 1992, May 13, 1993, June 1, 1993, August 12, 1993, August 12, 1994, September 1, 1995, August 14, 1996, November 10, 1997, April 13, 1998 and July 10, 1998. **Amended**: Filed; April 20,1999; effective July 13, 1999. A**mended**: Filed June 19, 2002; effective September 23, 2002. **Amended:** Filed August 22, 2005; effective November 16, 2005. **Amended:** Emergency Rule filed and effective March 21, 2006. **Amended:** Filed May 22, 2006; effective August 16, 2006. **Amended:** Filed November 17, 2008; effective February 11, 2009. **Amended:** Filed April 20, 2010; effective July 16, 2010.

Rule No. 560-X-25-.07. Development of Ownership Interest in Nonliquid Resources for SSI-Related Individuals.

(1) Ownership interest in Real Property - Establishment of ownership interest may be obtained by:

(a) Assessment notice;
(b) Recent tax file;
(c) Current mortgage statement;
(d) Deed;
(e) Report of title search;
(f) Wills, court records, or relationship documents which show rights of an heir to the property after death of the former owner.

(2) The laws of the State of Alabama regarding the validity of deeds, wills, mortgages, and other instruments which convey legal title to real property will govern all such determination.

(3) Types of Ownership - The type of ownership in real property is determined by the instrument, if any, conveying the real property, and by Alabama law. Ownership interests are arising through the death of a spouse or other relative are governed by the Alabama laws of descent and distribution and by those Alabama laws providing for the spouse and family of a decedent.

Authority: State Plan; Social Security Act, Titles XVI and XIX; 42 C.F.R. Section 401, et seq.; 20 C.F.R. Section 401, et seq.

Rule No. 560-X-25-.08. Development of Ownership Interest in Liquid Resources for SSI-Related Individuals.

(1) Cash - Cash on hand is always counted as liquid resource except when it is a business asset necessary to the operation of a trade or business that is excluded as necessary for self-support or under an approved plan for achieving self-support in the case of the blind or disabled.

(2) Checking, Savings, and Other Accounts -

(a) General.

These are countable resources if the applicant/recipient has unrestricted legal access to the accounts. This rule applies to individual accounts and joint accounts as well as certificates of deposit, savings certificates, and all forms of time deposits, whether held individually or jointly. This rule applies to accounts, deposits, etc., in any financial institution or being held by any financial or brokerage service or agency.

(b) Joint Accounts.

1. When only one holder of a joint account is an applicant/recipient who has unrestricted access to the funds in the account it is presumed that the applicant/recipient owns the total funds in the account.

2. When two or more eligible individuals or applicants are holders of the same joint account and each has unrestricted access to the funds in the account it is presumed that the eligible individual or applicant owns an equal share of the total funds in the account, regardless of the source of the funds.

3. Unrestricted access depends upon the legal structure of the account. When the accounts reads "or" or "and/or" and the applicant/recipient is legally able to withdraw funds from the account, he/she is considered to have unrestricted access to the total funds in the account.

(c) Rebuttal of Presumption.

The opportunity to rebut the presumption of ownership shall be afforded all applicants/recipients. In order for an applicant/recipient to rebut successfully the presumption of full or partial ownership, all of the following documentation is required:

1. A statement by the applicant/recipient on a form 234, giving:

(i) His/her allegation regarding no ownership or partial ownership of the funds documented by a statement from the financial institution, copy of the bank book, account book, certificate of deposit, etc., verifying the language of the account, and a copy of the signature card;

(ii) The reason for establishing the joint account;

(iii) Who made deposits to and withdrawals from the account, and how withdrawals were spent, documented with evidence such as wage statements, deposit slips, and employer's statements verifying source of deposits and cancelled checks; and

(iv) Corroborating statements on form 234 from the other account holder(s), or, if the co-holder of the joint account is incompetent or a minor, a statement from a

third party who has knowledge of the circumstances surrounding the establishment of the joint account.

2. If the rebuttal is successful and it is determined that the funds in the account do not belong to the applicant/recipient and should be excluded as a countable resource, a change in the account designation removing the applicant/recipient's name from the account or restricting access to the account must be executed and verification of such submitted as evidence before eligibility can be determined. If this change is not made and evidence is not submitted by the applicant/recipient within ten (10) days following notification, the presumption of ownership will apply.

(3) Promissory Notes, Loans, and Property Agreements (Mortgages) - Promissory notes, loans, and property agreements are considered resources, if the owner has the legal right to sell them. If so, the resources should be counted in the amount of the outstanding principal balance.

(4) Trusts - Whether the principal of a trust is a resource to the applicant/recipient depends on its availability to the applicant/recipient by the terms of the trust instrument itself.

Trusts or other similar legal devices may be excluded from consideration as a resource. Medicaid shall determine whether the requirements for exclusion expressed in the current statutory authorities have been met.

(5) Annuities- A lump sum annuity that can be sold, cashed in, surrendered or revoked will be considered a resource in the amount of the current value of the annuity unless a lesser value is satisfactorily documented.

(6) Stocks, Bonds, and Mutual Fund Shares - These are considered countable liquid resources according to their market value.

(7) Life Insurance - The cash surrender value of any life insurance policy owned by the applicant/recipient is a countable resource to the extent provided in 20 C.F.R. Section 416.1230.

(8) The foregoing are not intended to be an all-inclusive list of liquid resources. Any resource readily convertible into cash may be considered a liquid resource.

Author: Audrey Middleton, Associate Director, Policy Program Implementation Unit, Certification Support Division.
Statutory Authority: State Plan; Social Security Act, Titles XVI and XIX; 42 C.F.R. Section 401, et seq.; 20 C.F.R. Section 401, et seq; and 42 C.F.R. Section 416.
History: Rule effective October 1, 1982. Amended August 10, 1988, and September 9, 1997.
Amended: Filed November 19, 2003; effective February 13, 2004.

Rule No. 560-X-25-.09 Transfer of Assets Affecting Eligibility.

(1) An individual who is an applicant or recipient of institutional Medicaid or home and community based waiver services, or the spouse of such individual, who transfers an asset at any time on or after the look-back date, as defined in paragraph (11)(j), for less than fair market value for the purpose of establishing or maintaining eligibility will cause the individual to be charged with the difference between the fair market value of the asset and the amount of any compensation received. The difference is referred to as uncompensated value and is counted toward the resource limit of the individual for a period of time determined in accordance with paragraph (6) or (7).

(a) When there is an institutionalized couple and only one applies for Medicaid, any transfers of assets for less than fair market value within the look-back period made by the applicant and /or non-applying spouse affects the applicant's eligibility. In these situations, the applying spouse will incur the entire penalty period.

(b) If at a later time the applicant's spouse, who initially did not apply, makes an application, the remaining penalty period would be apportioned between them. Any fractional remainder will be served by either spouse.

(2) When a stream of income or the right to a stream of income, such as an annuity, is transferred, Medicaid shall make a determination of the total amount of income expected to be transferred during the owner's life, based on an actuarial projection of the owner's life expectancy as established by federal life expectancy tables, and calculate a penalty period based on the projected total income.

(3) The purchase of an irrevocable non-salable, non-transferable lump sum annuity before February 8, 2006, on or after the 60-month look-back date for the purpose of establishing or maintaining eligibility, will cause the individual to be charged with uncompensated value based upon the price of the annuity at the time of purchase. This uncompensated value is counted toward the resource limit of the individual for a period of time determined in accordance with paragraph (6).

(4) A transfer of an asset for less than fair market value is presumed to have been for the purpose of establishing or maintaining Medicaid eligibility unless the individual presents convincing evidence that the transfer was exclusively for some other purpose, in accordance with paragraph (9).

(5) Any individual who fails to disclose in an application a transfer of assets which occurred on or after the look-back date or who fails to report a transfer which occurs after eligibility is awarded, or who receives Medicaid benefits prior to discovery of a transfer of assets in violation of this rule shall be subject to recoupment action and suspension of benefits pursuant to Code of Alabama 1975, Section 22-6-8 and Chapters 4 and 33 of this Administrative Code. Such individual and/or his representative may also be subject to criminal prosecution under Code of Alabama 1975, Section 22-1-11 and Section 1128B of the Social Security Act (42 U.S.C. Section 1320a-7b).

(6) Penalty Period for Transfer of Assets Occurring Before February 8, 2006.

(a) This period is applicable to nursing facility services as defined in the State Plan, a level of care in any institution equivalent to that of nursing facility services as defined in the State Plan, and home and community based waiver services.

(b) The total, cumulative uncompensated value of the assets transferred on or after the look-back date will be divided by the average monthly cost to a private patient for nursing facility services in the state (at the time of application) as determined by Medicaid. This quotient, less the fractional remainder, shall be the number of months the uncompensated value is counted (the penalty period for the fractional remainder is incurred but not imposed, unless additional transfers occur in that month). This penalty period shall begin the first month after the month of transfer and shall run continuously under this rule, except that in the case of multiple transfers, no penalty period based on any transfer will begin before the first month after the month of that particular transfer.

(c) Transfers that result in a fractional remainder are not penalized for the month of the remainder, unless another transfer occurs during that month. In that case the penalty period must be recalculated using the cumulative total of the transferred assets. This is referred to as an overlapping penalty period.

(7) Penalty Period for Transfers of Assets Occurring On or After February 8, 2006.

(a) This period is applicable to nursing facility services as defined in the State Plan, a level of care in any institution equivalent to that of nursing facility services as defined in the State Plan, and home and community based waiver services.

(b) The total, cumulative uncompensated value of the assets transferred on or after the look-back date will be divided by the average monthly cost to a private patient for nursing facility services in the state (at the time of application) as determined by Medicaid. This quotient, minus the fractional remainder, shall be the number of months the uncompensated value is counted. The fractional remainder shall be converted to a dollar figure and added to the individual’s liability. This penalty period shall begin the month of transfer, or the first month in which the individual is eligible for medical assistance under the State Plan and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this Rule.

(8) Transfers Not Considered. An individual shall not be ineligible for medical assistance to the extent that:

(a) The assets transferred were a home and title to the home was transferred to:

1. The individual's spouse or child who is under age 21, or who is blind or permanently and totally disabled; for use as his or her residence;

2. A sibling of such individual who has an equity interest in such home and who has been residing in such individual's home, for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

3. A son or daughter of such individual (other than a child described in clause 1) who was residing in such individual's home for a period of at least two years immediately before the date of such individual becoming an institutionalized individual, and who (as determined by Medicaid) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility.

(b) The assets were transferred to (or to another for the sole benefit of) the individual's spouse or the individual's child who is blind or permanently and totally disabled. All funds transferred must be spent only for the benefit of the spouse or the child who is blind or permanently and totally disabled within a time frame actuarially commensurate with the life expectancy of the beneficiary.

(c) A satisfactory showing is made to Medicaid that the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, or the assets were transferred exclusively for a purpose other than to qualify for Medicaid.

(d) Medicaid determines that denial of eligibility would work an undue hardship.

(e) The assets were transferred to a trust which is determined to be exempt from consideration under §1917(d) of the Social Security Act.

(f) All assets transferred on or after the look-back date for less than fair market value have been returned to the individual. A return of the assets may cause ineligibility based on excess resources.

(9) Rebuttal.

(a) The burden is upon the individual to rebut the presumption that a transfer of an asset was made for the purpose of establishing or maintaining Medicaid eligibility by furnishing Medicaid with convincing evidence that the asset was transferred exclusively for some other purpose. Convincing evidence may be pertinent documentary or non-documentary evidence which shows, for example, that the transfer was ordered by a court, or that at the time of transfer the individual could not have anticipated becoming eligible due to the existence of other circumstances which would have precluded eligibility. A subjective statement of intent or ignorance of the provisions of this Rule is not sufficient, by itself, to rebut the presumption raised.

(10) Undue Hardship

(a) In situations where an individual has admitted that an asset has been transferred for less than fair market value for the purpose of obtaining Medicaid benefits, the Agency may still grant an exemption from the penalty period where the individual demonstrates by clear and convincing evidence that the imposition of such a penalty will cause the individual to suffer undue hardship. Undue hardship will only be considered in extreme cases where the individual has been denied admission to or discharged from an institutional facility or denied home and community based waiver services under circumstances which would deprive the individual of medical care such that the individual’s health or life would be endangered, or of food, clothing, shelter, or other necessities of life. Undue hardship does not exist where a transfer penalty causes a individual or the individual’s family to experience inconvenience or would cause a individual to restrict his/her lifestyle.

(b) In determining the existence of "undue hardship" Medicaid will consider all circumstances involving the transfer and the situation of the individual, including but not limited to, the following:

1. Whether the individual has been determined to be a person in need of care and protection pursuant to the Adult Protective Services Act, Code of Alabama 1975, §38-9-1, et seq.;

2. Whether the individual or his representative has exhausted all reasonable efforts to obtain a return of, or compensation for, the transferred asset, including voiding the

transfer pursuant to Code of Alabama 1975, §35-1-2 or §8-9-12, or diligently prosecuting other criminal or civil action available to recover the asset;

3. Whether the individual was deprived of an asset by fraud or misrepresentation. Such claims must be documented by official police reports or civil and/or criminal legal actions against the perpetrator;

4. Whether the individual or his representative has exhausted all reasonable efforts to meet the individual's needs from other available sources.

(c) When a penalty period is imposed, the Notice of Action will include notice that the individual or authorized representative may, as part of the review process, request the granting of an undue hardship exemption. A denied request may be appealed in accordance with Chapter 3 of this Code.

(11) Definitions. As used in this rule:

(a) "Transfer" is, and occurs at the time, when an individual or spouse (or a parent, guardian, court or administrative body, or anyone acting in place of or on behalf of or at the request or direction of the individual or spouse), by either affirmative act or failure to act, loses or relinquishes all rights of legal access to an asset or interest therein. (b)

"Compensation" is all money, real or personal property, food, shelter or services received by the individual or spouse at or after the time of transfer in exchange for the asset in question. Money, real or personal property, food, shelter or services received prior to the transfer are compensation only if they were provided pursuant to a legally enforceable agreement (i.e., personal service agreement, etc.) to provide such items in exchange for the asset in question. Services provided pursuant to a personal service agreement are compensation only if all the criteria set forth in Section (11)(k) of this rule are met. Payment or assumption of a legal debt owed by the individual or spouse in exchange for the asset is also compensation.

(c) "Fair market value" is the current market value of an asset at the time of the transfer or contract of sale, if earlier. Current market value shall be determined in accordance with Rule 560-X-25-.06(3), except that if a remainder interest in property is transferred, whether or not a life estate is retained, the uncompensated value will be based on the fair market value of the entire property at the time of the transfer or contract of sale, if earlier.

(d) "Uncompensated value" is the fair market value of the asset minus the amount of any compensation received by the individual or eligible spouse in exchange for the asset.

(e) A "home" is any shelter in which the individual (and spouse, if any) has an ownership interest and which is used by the individual (and spouse, if any) as his principal place of residence. The home includes any land that appertains thereto and any related outbuildings necessary to the operation of the home.

(f) The "month of application" is the month in which the original, initial application of an individual is received and accepted by the Medicaid Agency.

(g) "Assets" are all income or resources of the individual or the individual's spouse. This term includes income or resources which the individual or individual's spouse is or was entitled to but does not receive.

1. With respect to a transfer of assets on or after February 8, 2006, the term "assets" includes an annuity purchased by or on behalf of the individual and will be treated as a disposal of assets for less than fair market value unless:

(i) the annuity is--

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from--

(aa) an account or trust described in subsection (a), (c), (p) of section 408 of such Code;

(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(cc) a Roth IRA described in section 408A of such Code; or

(ii) the annuity--

(I) is irrevocable and non-assignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made; and,

(iii) in the annuity--

(I) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or

(II) the State is named as such beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value

2. With respect to a transfer of assets on or after February 8, 2006, the term “assets” includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home continuously for a period of at least 1 year after the date of the purchase. The purchase price must be actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration). Any excess purchase price will be treated as a transfer of assets for less than fair market value under the provisions of this Rule.

3. With respect to a transfer of assets on or after February 8, 2006, the term “assets” includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage--

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for institutional or home and community based waiver services.

(h) "For the sole benefit of: " A transfer is considered to be for the sole benefit of a spouse, or a blind or disabled child, if the transfer is arranged in such a way that no individual or

entity, except the spouse or the blind or disabled child, can benefit from the assets transferred in any way, whether at the time of the transfer or any time in the future.

(i) "Institutionalized individual" is an individual who is:

1. An inpatient in a nursing facility; or
2. An inpatient in a medical institution for whom payment is based on a level of care provided in a nursing facility.

For purposes of this rule, a medical institution includes an intermediate care facility for the mentally retarded (ICF/MR), as defined in 42 CFR 435.1009.

(j) "Look-back date" for an institutionalized individual is the date that is 36 months (or in the case of a trust, annuity or similar legal instrument, or in the case of any transfer of assets on or after February 8, 2006, 60-months) immediately prior to the later of the first day of the month of the original, initial application or the first day of the month that the individual becomes an institutionalized individual. For home and community based waiver cases, the "look-back date" is the date that is 36 months (or in the case of a trust, annuity or similar legal instrument, or in the case of any transfer of assets on or after February 8, 2006, 60 months) immediately prior to the later of the first day of the month of the original, initial application or the first day of the month in which the individual disposes of assets for less than fair market value.

(k) "Personal Service Agreement" is a legally enforceable written agreement for personal care services to be provided in exchange for anything of value. A transfer of assets is presumed to have occurred at the time of the exchange and a transfer penalty shall be imposed unless all of the following are met:

1. At the time of the receipt of the services, the services were recommended in writing and signed by the applicant's physician, as necessary to prevent the admission of the applicant to a nursing facility. Such services may not include the providing of companionship and related services;
2. At the time of the receipt of the services, the applicant was not residing in a nursing facility;
3. At the time of the receipt of the services, the transfer of the consideration (money and/or property) to the provider/relative occurred; and
4. At the time of the receipt of the services there already existed a written and signed agreement executed between the applicant and provider for the specific service(s) rendered.

(i) The agreement executed between the applicant and provider/relative must fully describe the type, frequency and duration of the services being provided to the applicant in such a way that they can be documented when provided; and the amount of consideration (money and/or property) being received by the provider/relative.

(ii) The agreement executed between the applicant and provider/relative must provide that the amount of consideration (money and/or property) cannot exceed the fair market value for that rendered service(s). Rates for these services must be shown to be comparable to the usual and customary rates in the local area. The fair market value of the services may be determined by consultation with an area business which provides such services.

(iii) Services that are provided pursuant to a valid personal services agreement must be documented with time sheets and attendance logs for each hour of services

provided. Contracts cannot provide for a "lump sum" payment regardless of the services that are to be provided, as each service must be individually documented to be justified.

(iv) Payment must only be for actual services rendered. Any reimbursement for out-of-pocket expenses incurred by the caregiver must be documented by a receipt.

Author: Audrey Middleton, Associate Director, Policy/Program Implementation Unit, Certification Support Division
Statutory Authority: Social Security Act, §1613, and §1917; 20 C.F.R. §416.1246; 42 C.F.R. 430 Subpart B; Code of Alabama, 1975, §35-1-2 and §8-9-12; State Plan; Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360, Section 303); Section 608(d) of the Family Support Act; and Section 13611 of the Omnibus Budget Reconciliation Act of 1993; and Deficit Reduction Act of 2005 (P.L. 109-171).
History: Rule effective October 1, 1982. Repealed and new rule adopted in lieu thereof effective June 9, 1986. Amended January 14, 1987. Emergency Rule effective September 30, 1988. Repealed and new rule adopted in lieu thereof effective January 10, 1989. Amended June 16, 1989; and May 14, 1991. Emergency Rule effective June 1, 1993. Amended August 12, 1993 and July 11, 1995, and January 11, 1996. **Amended**: Filed November 19, 2003; effective February 13, 2004. **Amended:** Filed March 22, 2004; effective July 1, 2004. **Amended:** Emergency rule filed and effective March 21, 2006. **Amended:** Filed May 22, 2006; effective August 16, 2006. **Amended:** Filed March 20, 2008; effective June 16, 2008.

Rule No. 560-X-25-.10. Income Criteria for SSI-Related Individuals.

(1) The income limit for the institutional Medicaid program and certain home and community based waiver programs is determined by the Agency and published in the State Plan for Medical Assistance. The income limit is equal to 300 percent of the current SSI benefit amount payable to an individual in his own home who has no income.

(2) The income limit for certain recipients of home and community based waiver services who are eligible for Medicaid solely because they require and receive services under a home and community based services waiver is the SSI federal benefit rate plus the $20.00 general disregard.

(3) Rules in 20 C.F.R. 416 Subpart K govern types of countable income and income exclusions except as further limited by §36-27-21.1 of the Code of Alabama (1975).

(4) In determining the amount of income an individual has to apply to his cost of care in an institution, the following are deducted:

(a) amounts of income protected for personal needs subject to the limits as set forth in the Agency State Plan, Attachment 2.6-A.

(b) amounts of income protected for the maintenance needs of the ineligible spouse and dependents living outside the facility.

(c) amounts of income protected for health insurance premiums that are paid by the applicant/recipient.

(d) amounts of income for incurred necessary medical or remedial care recognized under state law but not covered under the State's Medicaid Plan, nor subject to

payment by Medicare or any other third party health insurance including Medicare premiums, deductibles and coinsurance.

1. The incurred necessary medical or remedial care must be determined to be medically necessary. All verification needed to make the determination of medical necessity and to allow the deduction must be furnished to the agency within six months of the date of the service.

2. A deduction for expenses incurred for medically necessary non-covered medical or remedial care will be allowed based on the lesser of the Medicaid rate, the Medicare rate, or reasonable and customary charges.

3. A deduction for incurred medically necessary non-covered medical or remedial care expenses will be allowed when the bill is incurred during a period which is no more than three months prior to the month of current application.

4. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

5. A deduction for initial or replacement dentures will be allowed for those meeting Agency established medical necessity criteria.

6. A deduction for hearing aids will be allowed for those meeting Agency established medical necessity criteria.

7. A deduction from the individual's income for incurred necessary medical or remedial care is only applicable when the individual has available income to allow for an offset (liability amount to the nursing home is greater than zero).

(5) The following are more liberal income requirements than SSI for determining the eligibility of individuals as Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries, and Qualifying Individuals-1:

(a) The consideration of in-kind income support and maintenance in the income calculation is waived.

(b) Fluctuating income may be averaged for the past six months and projected for twelve months.

(c) Interest and dividend income is excluded.

Author: Audrey Middleton, Associate Director, Policy and Program Implementation, Certification Support Division.

Statutory Authority: State Plan; Social Security Act, Titles XVI and XIX; 1902(r)(2); 42 CFR §401, et seq.; Code of Alabama, 36-27-21-.1; and 42 CFR, §435.725. 42 CFR 435.231; 42 CFR 435.726; Section 1611(b)(1); Section 1915(c) and Section 1902(a)(10)(A)(ii)(VI).

History: Rule effective October 1, 1982. Amended November 10, 1983; July 9, 1984; July 9, 1985; January 8, 1988; April 12, 1988; July 13, 1990; October 9, 1990; January 15, 1991; July 13, 1991; November 12, 1992; May 1, 1993; and August 12, 1993. **Amended:** Filed February 17, 2006; effective May 16, 2006. **Amended:** Filed May 22, 2006; effective August 16, 2006.

Rule No. 560-X-25-.11. Additional Criteria for Institutional Care.

(1) In addition to the rules covered in Rule 560-X-25-.05 through .11 the following criteria must also be met for an individual to qualify for Medicaid in a Title XIX institution:

(a) The individual must be certified as needing the level of care received in an institution and as having a continuing need for institutionalized care.

(b) The individual must be in a facility certified to participate in the Medicaid program and which has a current provider agreement with the Medicaid Agency.

(2) In order for an individual institutionalized in a hospital or nursing home to qualify for the maximum income limit allowed for institutionalized Medicaid recipients, as described in Rule No. 560-X-25-.10, the individual must have been a resident of a Title XIX medical institution for 30 consecutive days or longer.

(a) Being a resident of an institution for 30 consecutive days means being a resident for the period beginning with day one until the last instant of the 30th consecutive day.

Authority: Social Security Act, Title XIX, 42 C.F.R. Section 401, et seq.; State Plan; Chapter 10 this Code. Rule effective October 1, 1982. Amended March 15, 1983. Effective date of this amendment August 10, 1987.

Rule No. 560-X-25-.12. Periods of Entitlement.

(1) The earliest date of entitlement for Medicaid is the first day of the month of application for assistance under one of the categorical programs, provided the individual meets all factors of eligibility for that month. The individual who is eligible on the first day of the month is entitled to Medicaid for the full month.

(2) An exception to (1), above, is Retroactive Medicaid Coverage. Individuals who have incurred medical expenses for the three months immediately preceding the month of application for Medicaid or the three months prior to the receipt of the first SSI check (for SSI cases), may become eligible for Medicaid benefits during that time provided all eligibility requirements are met for each month. Application for Retroactive Medicaid must be made within six months from the month of notification of award of Medicaid benefits and/or cash assistance.

(3) When a family is terminated from Medicaid for Low Income Families because of earnings of the caretaker relative, including earnings from new employment or increased earnings or increased hours of employment, Medicaid may be provided for up to 12 calendar months beginning with the month Medicaid for Low Income Families is terminated, provided the family correctly received Medicaid for Low Income Families in 3 of the immediately preceding 6 months. To be eligible for the first 6 month Medicaid extension, the assistance unit must continue to include a dependent child. To be eligible for the second 6-month Medicaid extension, the assistance unit must have complied with specified reporting requirements in the initial 6 months of benefits; continue to include a dependent child; have a gross family income (less work-related child care expenses) that does not exceed 185% of the Federal Poverty level in

the immediately preceding 3 months; and the caretaker relative must have earnings in one or more of the immediately preceding 3 months.

Authority: Social Security Act, Titles XVI and XIX; 42 CFR §435.914; State Plan. Rule effective October 1, 1982. Amended March 11, 1986; January 14, 1987, September 13, 1990 and November 12, 1993. Effective date of this amendment January 12, 1998.

Rule No. 560-X-25-.13 Adults in Need of Protective Services.

For adults in need of protective services (as defined by Code of Alabama (1975) Section 38-9-2, et seq.), property may be excluded during the period from the date the petition is filed to the date of the court order, but in no event for a period to exceed 120 days.

Author: Aljanetta C. Rugley, Policy/Research Specialist, Policy and Program Implementation, Certification Support Division.
Statutory Authority: Code of Alabama (1975) Section 38-9-2, et seq.
History: Rule effective October 1, 1982. Amended: Filed May 22, 2001; effective August 16, 2001.

Rule No. 560-X-25-.14 Pregnant Women and Young Children With Income Equal To or Below 133% of the Federal Poverty Level and Children With Income Equal To or Below 100% of the Federal Poverty Level.

(1) Medicaid coverage under poverty provisions is available for pregnant women and young children meeting the requirements listed below:

(a) The family unit income must be equal to or less than 133% of the current federal poverty level.

(b) For pregnant women, pregnancy must be verified.

(c) Children's eligibility will continue through the month of their 6th birthday.

(d) The person to be covered must be living in Alabama and must be a United States citizen or meet alienage requirements.

(e) Any private insurance benefits must be assigned to the State.

(f) Application must be made for any other benefits for which the person's family appears eligible.

(g) Changes in income and/or living arrangements must be reported at annual review.

(h) The person to be covered must furnish or apply for a Social Security number.

(2) Medicaid coverage under poverty provisions is available to children with income below 100% of the Federal Poverty Level meeting the requirements listed below:

(a) The family unit income must be equal to or less than 100 % of the current federal poverty level.

(b) The child must be at least six years of age.

(c) Children's eligibility will continue through the month of their 19th birthday.

(d) The child to be covered must be living in Alabama and must be a United States citizen or meet alienage requirements.

(e) Any private insurance benefits must be assigned to the State.

(f) Application must be made for any other benefits for which the person's family appears eligible.

(g) Changes in income and/or living arrangements must be reported at annual review.

(h) The person to be covered must furnish or apply for a Social Security number.

Author: Audrey Middleton, Associate Director, Policy and Program Implementation, Certification Support Division.
Statutory Authority: Section 6401 of P.L. 101-239, Omnibus Budget Reconciliation Act of 1989 (OBRA 89). Section 4601 of P.L. 101-508, Omnibus Budget Reconciliation Act of 1990 (OBRA 90).
History: Emergency Rule effective September 1, 1991. Permanent rule effective December 12, 1991. **Amended:** Filed February 19, 1999; effective April 1, 1999. **Amended:** Filed October 19, 2001; effective January 16, 2002. **Amended:** Filed April 19, 2002; effective July 17, 2002. **Amended:** Emergency Rule Filed and effective April 9, 2003. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-25-.15 Medicaid for Low Income Families, Extended Medicaid Benefits due to State Collected Child Support, and Transitional Medicaid Benefits.

(1) Medicaid for Low Income Families (MLIF): "Medicaid for Low Income Families" means individuals eligible for Medicaid through the Medicaid for Low Income Families Program or who meet the eligibility criteria for Medicaid for Low Income Families based on policies in effect for the AFDC program as it existed on July 16, 1996, as follows:

(a) Financial Requirements:

The family must have a child in need by Agency rules. To be considered "in need" a family may not have (1) total gross monthly income which exceeds the established gross income limit; or (2) net monthly income which equals or exceeds the eligibility standard. In establishing need, income of all persons in the family is considered. Before earned income is counted, the following deductions are allowed from gross earnings: $90 per month for work expenses; $30 plus 1/3 of the remainder of earned income and child/dependent care for up to $200 per month for the care of each dependent under age 2 and up to $175 per month for each dependent age 2 and older or incapacitated adult. A $50 disregard is allowed per family for child support received. Lump-sums are considered income and added to other monthly income, this amount is then compared to the agency need standard to determine periods of ineligibility.

(b) Medicaid Standards:

Family Size	Gross Income Limit	Eligibility Standards	Needs Standard
1	845	111	457
2	1042	137	563
3	1245	164	673
4	1467	194	793
5	1704	225	921

6	1909	252	1032
7	2172	287	1174
8	2375	315	1289
9	2599	344	1405
10	2812	372	1520
11	3025	400	1635
12	3239	428	1751
13	3452	457	1866
14	3665	485	1981
15	3879	513	2097
16	4092	541	2212

(c) Family Criteria

1. "Family" means all persons included in determining family size. Generally, persons to be included are the natural or legal parents and blood related or adoptive siblings of the child(ren) living in the home, who meet the age requirements and are otherwise eligible for Medicaid. (If the child or a sibling group is included, all his siblings who reside in the home and who meet the age requirements and are otherwise eligible can be included). Families whose countable income equals or exceeds the eligibility standard for the appropriate family size are not eligible for Medicaid for Low Income Families, but some members may be eligible for another category of Medicaid administered by the Alabama Medicaid Agency.

2. Degree of relationship must be verified and the caretaker must be of a specified degree of relationship to the child. A relative other than a parent may be eligible if their income does not exceed the Medicaid Standard. The persons must be blood relatives of the half-blood or the whole-blood and relatives who have ever been "in-law" or "step" within the degrees listed below. This is an exclusive listing:

(i) Females – mother, adoptive mother, stepmother (but not her parents), sister, adoptive sister, stepsister, sister-in-law, aunt, great-aunt, great-great aunt, aunt-in-law, grandmother, great-grandmother, great-great grandmother, great-great-great grandmother, step-grandmother (meaning the subsequent wife of the child's natural grandfather), adoptive grandmother (meaning the mother of a parent who was adopted), niece, first cousin, first cousin once removed (meaning the first cousin of the dependent child's parent or the child of the dependent child's first cousin.), spouses of any individual listed under males.

(ii) Males – Father, adoptive father, stepfather (but not his parent), brother, adoptive brother, stepbrother, brother-in-law, uncle, great-uncle, great-great uncle, uncle-in-law, grandfather, great grandfather, great-great grandfather, great-great-great grandfather, step-grandfather (meaning the subsequent husband of the child's natural grandmother), adoptive grandfather (meaning the father of a parent who was adopted), nephew, first cousin, first cousin once removed (meaning the first cousin of the dependent child's parent or the child of the dependent child's first cousin.), spouses of any individual listed under females.

3. Forms of verification:

(i) Primary sources: Birth record, school records, sworn, notarized or witnessed statement of applicant/recipient, affidavit of paternity, hospital birth record, court orders signed by the judge where the relationship is acknowledged as claimed and there is no evidence to the contrary. If no primary documentation use Declaration of Natural Relationship

form with the applicant/recipient or other persons with knowledge of the relationship and secure secondary verification.

(ii) Secondary sources: Insurance policy, other agency records, (example Red Cross, SSA, Census records, VA, Department of Senior Services records, Department of Human Resources), bible records, income tax records, official records, (example school report card, juvenile court), other hospital records, clinic or Health Department records, church records, military records, statement from a minister, priest or rabbi, baptismal certificate or other.

(d) Technical Requirements:

1. The child must be living in the home of a parent or other close relative (relationship must be verified in all cases).
2. The child must be under age 19.
3. The child must be a U.S. citizen or an alien in satisfactory immigration status.
4. The child must not be receiving at the same time in his own right any other form of Medicaid.
5. The caretaker must cooperate with the Department of Human Resources and Alabama Medicaid Agency in Medical Support Enforcement Activities and in Third Party Medical Liability Activities unless good cause for not cooperating is determined.
6. When application is made for a child(ren) the relative who cares for him/her (them) automatically assigns to the State all medical insurance or medical support benefits to the extent medical assistance is provided him/her or a child in their care.
7. The parent/caretaker must furnish all Social Security numbers for everyone in the household or apply for a Social Security number for anyone who does not have a number and furnish the number upon receipt. (These numbers will be used in addition to any other means of identification in the administration of the program as provided for in Section 402(a)(25) of the Social Security Act). The number provided will be used in computer matches, program reviews and audits. Eligibility and income information will be requested regularly from the Internal Revenue Service, Social Security Administration, Alabama Department of Industrial Relations and other public and private organizations.
8. The parent/caretaker must apply for any other benefits for which they or other members of the household appear to be eligible, such as Veteran Benefits, Social Security, Unemployment Compensation, etc.

(e) The Agency uses less restrictive income and resource methodologies than those in effect as of July 16, 1996, as follows:

1. Resources are excluded.
2. A child shall be considered to be deprived of parental care of one or both parents if the family income does not equal or exceed the eligibility standards for the appropriate family size, even though both parents may live in the home.
3. The $90 work expense, $30 and 1/3 disregards are applied for 12 consecutive months.
4. Contributions of $50 per individual per quarter is allowed.
5. Income may be deemed for: spouse to spouse, senior parent to minor parent, and stepparent to spouse based on income that exceeds the Standard.

(f) The following individuals are deemed to be eligible for Medicaid for Low Income Families:

1. MLIF qualified pregnant women whose family income falls within the standards for Medicaid for Low Income Families.

2. Individuals under age 19 who would qualify for Medicaid for Low Income Families but do not qualify as dependent children because they are children for whom public agencies have assumed custodial and financial responsibility and they are in foster homes or private institutions.

(2) Extended Medicaid Benefits due to State Collected Child Support

All persons who are correctly members of the household that becomes ineligible for Medicaid for Low Income Families due wholly or partly to the collection or increased collection of child support are entitled to extended Medicaid coverage for four months (children eligible for 12 continuous months) provided:

(a) The case was terminated (wholly or partly) due to the collection or increased collection of child support; and

(b) The household (or any member of the household) **correctly** received Medicaid in Alabama for at least three of the six months immediately prior to the first month of ineligibility.

(3) Transitional Medicaid Benefits

When a family loses eligibility for MLIF because of earned income and has **correctly** received MLIF under this group in at least three of the preceding six months, the family is entitled to up to 12 months Transitional medical assistance. This is known as Transitional Medicaid benefits. Once eligibility is established, children are eligible for 12 continuous months following the month of the transitional Medicaid eligibility determination. In order to be eligible, the family must file timely quarterly reports and the family's earned income, minus the cost of child care, must not exceed 185 percent of the Federal poverty level.

(a) The household is eligible for Transitional Medicaid for the initial six months provided:

1. The household correctly received MLIF in Alabama for at least three of the six months immediately prior to the first month of ineligibility, and

2. The case was terminated due wholly or partly to the parent/caretaker's increased earnings or hours of employment, or

3. The case was terminated due wholly or partly to expiration of the $30 and 1/3 disregards applied to any adult(s).

(b) The parent/caretaker is eligible for the first six months of Transitional Medicaid coverage based on the termination reason. Children are eligible for 12 continuous months. The only reason (other than to return to regular MLIF eligibility) Transitional Medicaid coverage may be terminated in any one of the <u>first</u> six months is that the household ceases to include a child and then, only the Transitional Medicaid of the adult(s) may be terminated.

(c) Medicaid coverage may be extended to the parent/caretaker for an additional six months provided:

1. The parent/caretaker is employed in each of the 12 months unless there is good cause for terminating employment, and

2. The household continues to include a child, and

3. The household's average gross earnings, less child care expenses necessary for the employment of the parent/caretaker, do not exceed 185% of the federal poverty level, and

4. The household submits a completed quarterly report by the 21st of the fourth, seventh and tenth months of the extended benefits period. The quarterly report must contain information regarding gross earnings and childcare expenses for the three months prior to the month the report is due. Income must be verified.

Author: Audrey Middleton, Associate Director, Policy and Program Implementation, Certification Support Division.
Statutory Authority: Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
History: Emergency Rule Filed and Effective April 9, 2003. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-25-.16 Income and Resources of a Married Couple for Institutional Care

(1) The Medicare Catastrophic Coverage Act (MCCA) of 1988 provides for the special treatment of income and resources of a married couple. The special treatment is to protect the income and resources for the maintenance needs of the community spouse while the spouse is in a medical institution or nursing facility. The MCCA provisions apply to all claimants admitted to the medical institution or nursing facility on or after 9/30/89.

(2) The following definitions apply:

(a) SPOUSE - Person legally married to another under State law. The SSI definition as applied to the QMB/SLMB cases is not applicable to spousal cases. Legal marriage is a traditional marriage conducted by legal authority or a common law marriage recognized by a court.

(b) INSTITUTIONALIZED SPOUSE (IS) - Legally married person who resides in a medical institution or nursing facility and can reasonably be expected to continue to reside in the medical institution or nursing facility for a continuous period.

(c) COMMUNITY SPOUSE (CS) - Legally married person who is not living in a medical institution or nursing facility, and has a spouse residing in a medical institution or nursing facility.

(d) CONTINUOUS PERIOD OF INSTITUTIONALIZATION - At least 30 consecutive days of institutionalization in qualified medical institutions and/or nursing facilities.

(e) OTHERWISE AVAILABLE INCOME - Income that would be used to determine eligibility without benefit of disregards (including federal, state and local taxes) - gross income as defined by SSI.

(f) MAINTENANCE NEEDS STANDARDS - Income standards against which community spouses' and other family members' incomes are compared for purposes of determining the amount that can be allocated in the post-eligibility calculation.

(g) MONTHLY MAINTENANCE NEEDS ALLOWANCE - An allowance made from the institutionalized spouse to the community spouse or other dependent family members to meet his or her needs in the community.

(3) A monthly maintenance amount (allocation) can be protected for the spouse and family dependents at home.

(a) Spousal Impoverishment - To determine eligibility for an institutionalized claimant, who becomes institutionalized on or after September 30, 1989 and who has a community spouse, all resources {assets} (whether owned jointly or individually by either spouse) must be combined beginning with the point that a spouse was institutionalized. A spousal share is the greater of the minimum protected resource amount or 1/2 of the combined countable resources {assets}, not to exceed the maximum federal limit. The determination will be made using the total combined resources {assets} at the point a spouse is institutionalized. The assessment is to be completed at the request of either of the married couple, a representative acting on behalf of either spouse, or at the time of application for Medicaid benefits. The assessment is to be accomplished in a prompt manner.

(b) When a married couple is both institutionalized and both apply, each is treated as individuals rather than as a couple. Treatment as individuals begins as of the first day of the month following the month both are institutionalized. Spousal impoverishment rules do not apply and an assessment of resources shall not be conducted.

(c) If a married couple is institutionalized and only one applies for Medicaid, they are treated as individuals as of the beginning of the first full month of separation. Income and assets of the ineligible spouse must be deemed during the partial month.

(d) Spousal impoverishment rules apply to legally married couples when one enters a medical institution or nursing facility while the other remains in the community. The institutionalized spouse must remain in an institution 30 continuous days or longer.

(e) Spousal impoverishment does not apply if a claimant is not legally married at the time he/she enters the medical institution or nursing facility, unless he or she subsequently marries.

(f) If there is a change in circumstances such that there is no community spouse or institutional spouse, spousal impoverishment provisions cease to apply. The effective date of the cessation is the first full month following the change in status, for example, the community spouse enters a medical institution or nursing facility; or if the marriage is ended by death, divorce or annulment.

(g) The spousal impoverishment resource {assets} provisions do not apply to a claimant who is in a medical institution or nursing facility before 9/30/89. It would apply after readmission, if the claimant was originally admitted before 9/30/89 but left an institutional facility for 30 consecutive days or longer and then reenters the institution or facility.

(h) In order for spousal impoverishment rules to apply there must be a community spouse both at the point of institutionalization and at the point of application.

(i) If the claimant marries after the initial determination of eligibility, spousal rules apply. The resource assessment is computed based on the assets owned by the couple, individually or jointly, at the beginning of the institutionalized spouse's most recent continuous period of institutionalization even though that point precedes the point in time where there is a known community spouse.

(j) If both spouses enter an institution at the same time, but one spouse returns to the community, an assessment must be completed. The assessment is computed based on the resources {assets} owned by the couple (individually or jointly) at the beginning of the institutionalized spouse's most recent continuous period of institutionalization, even though both spouses were institutionalized at that point.

(4) When a claimant for Medicaid was divorced during the look-back period (36-60 months), the district office should review the divorce settlement. If the claimant did not receive an equal share of the marital estate, it may be considered to be a transfer of resources.

(5) The following rules apply in determining ownership of income for eligibility purposes:

(a) Consider available to each spouse one-half of any income paid in the name of both spouses,

(b) Consider any income paid solely to each spouse as income to that spouse,

(c) Consider income paid in the name of another party and both spouses, or one spouse, available to each spouse in proportion to each spouse's interest (or one-half of the total amount to each when payment is made to both spouses),

(d) Consider available to each spouse, one-half of any income that has no instrument establishing ownership. The institutionalized spouse is allowed to submit evidence to Medicaid to rebut the determination of available income (other than trust income). Prenuptial agreements are not binding nor considered for Medicaid eligibility purposes or for spousal impoverishment.

(e) If the institutionalized spouse is the grantor of a trust providing for payment of income to him or her, the maximum amount payable by the terms of the trust will be counted as available. No income paid only to a community spouse shall be counted in determining eligibility or amount of the payment to the nursing home for the institutionalized spouse for any month of institutionalization. The rule on trust income incorporates Section 1902(k) of the Social Security Act, the Medicaid Qualifying Trust provision.

(6) Compare the institutionalized spouse's countable income to the institutional income limit.

(a) After the institutionalized spouse has been determined income and resource eligible, determine the amount of income, if any, to be applied toward the cost of institutional care (i.e., liability amount) by deducting the following from the institutionalized spouse's income in the following order: 1. Personal Needs Allowance, 2. Community Spouse Monthly Maintenance Needs Allowance, if applicable, 3. Family Maintenance Needs Allowance, if applicable, 4. Amount for Health Insurance premiums, if applicable. The remainder should be the amount the claimant must pay to the nursing facility. In the case of a divorced couple, alimony is not considered to be an income deduction for decreasing the liability amount to be paid to the nursing facility.

(7) The minimum monthly maintenance needs standard for the community spouse is recalculated each year. Changes, if any, in this amount are effective in July. The community spouse monthly maintenance needs allowance is determined as follows: Deduct the community spouse's monthly income from the minimum monthly maintenance needs standard. This amount

is published each year by HCFA and is 150 percent of the federal poverty level for a couple. Available income of the community spouse includes income that would be used to determine eligibility for the claimant, without benefit of disregards (including federal, state, and local taxes)(gross income according to SSI standards). Any remaining amount is the monthly maintenance needs allowance (if allocated to the spouse). This amount is used in the post-eligibility calculation for allocation to the community spouse. If in excess, an allowance is not made available. When allowances are not made available to (or for the benefit of) the community spouse, Medicaid will not deduct the allowance. The following are mandated deductions for the institutionalized spouse and may reduce the monthly maintenance needs allowance for the community spouse: (1) personal needs allowance, (2) aid and attendance allowance, (3) Veterans Administration payments for unusual medical expenses.

(8) A maintenance needs allowance may be provided from the institutionalized spouse to other dependent family members. The dependent family member is defined as: a minor child, dependent adult child, dependent parent, or dependent sibling of either spouse, who is living with the community spouse and who is listed on the federal tax forms as a dependent (Internal Revenue Service tax dependent) of the community spouse.

(a) Allowances for each family member are determined as follows: Step 1. Deduct the gross income of the family member from the community spouse minimum monthly maintenance standard; Step 2. Divide the remainder in Step 1 by 3. Step 3. The remainder in Step 2, rounded down to the nearest dollar, is the minimum family monthly maintenance needs allowance used in the post-eligibility calculation to be allocated to the family member. If in excess, an allowance is not made available, deduct allowances for other family members, regardless of whether institutionalized spouses make their income available to such persons.

(b) When there is no community spouse and there are other family members, the current MLIF (formerly AFDC) payment standard will be used. The total number of family members at home will be computed against this table. This standard will be used when there are other family members, even though in some instances the needs allowance will be less than that of a spouse only. Any income of the family at home will be deducted from the standard to determine allocation. If the family at home has no income, the standard will be allocated. If the income of the institutionalized spouse is below the standard, the entire income will be allocated except for the protected personal needs allowance and the veterans aid and attendance allowance, veterans reimbursement for continuing unusual medical expenses. The current MLIF (formerly AFDC) definition of family units will be used in determining who is a family member.

(9) Medicaid shall "pool" the resources {assets} of an institutional and community spouse when:

(a) Either spouse requests an assessment at the beginning of the institutionalized spouse's first continuous period of institutionalization beginning on or after September 30, 1989.

(b) Although the couple may not have requested an assessment at the time one of the married couple was institutionalized, the agency shall determine total combined resources {assets} existing at the point of institutionalization when an application is filed. At the time of application for Medicaid, the Medicaid Agency computes the total combined value of the resources {assets} of the couple and a spousal share which is equal to 1/2 of the total value, or the minimum protected resource amount, whichever is greater. The assessment will be

conducted at the time and date of institutionalization, and at the time of initial eligibility determination (i.e., eligibility or ineligibility). All of the resources {assets} owned by either the institutionalized spouse or the community spouse, or both, shall be considered to be available to the institutionalized spouse, except for a specific "protected amount" for the community spouse (i.e., the spousal share) not to exceed the maximum federal limit.

At the beginning of a continuous period of institutionalization of a spouse, the district office shall use the following criteria to determine Medicaid eligibility for the first month of a continuous period of institutionalization:

1. Step 1. List all combined countable resources {assets} owned individually or jointly by the couple at the date and time of entry to the medical institution or nursing facility. The following types of otherwise excluded resources {assets} shall be included in the assessment: Equity value of real property normally excluded from assets due to a bona fide effort to sell; equity value of real property normally excluded from assets because it is jointly owned, and the sale of the property would cause the other owner undue hardship because of the loss of housing; and/or equity value of real property normally excluded because of a legal impediment; equity value of real property normally excluded because it is income producing.
2. Step 2. Determine total value of items listed in the above procedure. If the total in Step 2 is less than State Standard, stop here. All resources {assets} may be assessed to and for the use of the community spouse. If the amount in Step 2 exceeds the State Standard, go to Step 3.
3. Step 3. Determine 1/2 of total resources {assets} in Step 2.
4. Step 4. Compare amount in Step 3 with the Maximum Protected Resource Amount. If the amount is less than the Maximum Protected Resource Amount, protect that amount for the community spouse. If it is more than the Maximum Protected Amount, protect the maximum amount allowed for the community spouse.
5. Step 5. Subtract the amount in Step 4 from the total amount in Step 2 above. The remaining amount is a countable resource {asset} to be used for the institutionalized spouse. If this amount exceeds the current resource {asset} limit for an institutionalized case, the claimant is ineligible until those assets any assets accumulated during the spend down period are spent down to the appropriate level.
6. During the continuous period of institutionalization, after the month in which an institutionalized spouse is determined to be eligible, no resources {assets} of the community spouse shall be deemed to the institutionalized spouse.
7. Once an assessment has been made, a new assessment can only be made if the claimant is discharged from the nursing facility or medical institution for 30 continuous days and then readmitted for another 30 continuous day period. The assessment can be reevaluated if it is determined that inaccurate information was provided during the original assessment. Only the resources {assets} on hand at the point of continuous institutionalization of the institutionalized spouse, and the value of those resources {assets} can be used in the reevaluation of the assessment. After the assessment is completed, the amount attributed to the institutionalized spouse and any additional money accumulated or acquired by either spouse, must be spent down to $2,000.00 on the institutionalized spouse in order to be eligible. Gifts do not qualify as spend down. The institutionalized spouse may spend the money on nursing home care, items he or she needs in the nursing home, to pay legitimate debts belonging solely to him or her, maintenance on property in proportion to the ownership interest, or other appropriate expenses. If the community spouse or institutionalized spouse acquires additional resources

{assets} during the spend down period, those additional resources {assets} must be spent down also. The only amount that the community spouse can retain, prior to and at the time of the effective date of eligibility for institutionalized Medicaid benefits, is the protected amount determined in the assessment. After the effective date of eligibility for institutionalized Medicaid benefits, no resources of the community spouse shall be deemed available to the institutionalized spouse.

8. For claimants who become institutionalized on or after September 30,1989, under the resource {asset} rules, the community spouse resource {asset} allowance is deducted from the couple's combined countable resources {assets} at the point of continuous institutionalization, and at the point of award in determining the eligibility of the institutionalized spouse.

(10) The procedure for applying spousal impoverishment in situations when the community spouse cannot be located, is alleged deceased, or refuses to cooperate with the claimant shall be as follows:

The record shall contain a sworn statement of the claimant or other person regarding the community spouse. The sworn statement should be completed by the spouse and/or anyone with knowledge of the whereabouts of the community spouse and must show the following: Last known name; last known address; forwarding address at the post office; last known employment; circumstances surrounding disappearance; health of the individual at time of disappearance; state of mind of the individual at time of disappearance; efforts to locate; SSN/VA claim number/other identifying information on the individual; if alleged to be deceased, obtain death certificate from the Department of Public Health.

The eligibility specialist must follow up on any leads noted above and must verify the following: financial accounts, property, and employment.

When evaluating information on resources, the following applies:

1. If sufficient information is available to determine that excess resources do not exist, the case may be awarded.

2. If insufficient information is available to determine if the resources are or are not within the resource limit such as knowledge of resources but the value cannot be verified, the case must be denied.

3. If information is available to make a determination that excess resources exist and the claimant or sponsor claims an undue hardship exists, the case will be sent to the Elderly/Disabled Certification Division so that the Office of General Counsel can determine if an undue hardship exists. If the undue hardship exists, the case may be awarded. If there is no undue hardship, the case must be denied.

(11) Transfers by the community spouse to a person or persons other than the institutionalized spouse result in periods of ineligibility for nursing home payments for the institutionalized spouse. The institutionalized spouse will need to actually transfer (within 12 months) sufficient resources {assets} to equal the amount of the allowance to the community spouse so that such resources {assets} do not continue to cause ineligibility.

(12) All countable resources in excess of the amount protected for the community spouse, in the assessment, shall be countable resources to the institutionalized spouse whether they are in the name of the institutionalized spouse or community spouse.

(13) RULES BEFORE SEPTEMBER 30, 1989 AND BEFORE OCTOBER 1, 1990 RELATED TO COUPLES - TREATMENT OF INCOME AND RESOURCES

(a) Before the Medicare Catastrophic Coverage Act of 1988 (MCCA), treatment of a couple's income and resources depended on the living arrangement as of the first of a month. The rules below apply to persons admitted to the nursing facility before 9/30/89. Income and resources are deemed from spouse to spouse during the partial month (month of separation) when one spouse enters an institution and the other spouse remains at home. The institutionalized spouse is treated as an individual effective the first day of the month he or she fulfills the institutional residency requirement. Deeming of income and resources no longer applies. If eligible, the community spouse and/or family members could receive a designated allocation amount at home. This allocation is deducted from the institutionalized spouse's liability amount.

(b) Before 10-1-90, income and resources of a couple were treated as two individuals after they had been living together (sharing a room) in an institution for six months. Beginning 10-1-90 when both members of a couple are institutionalized and both apply, both members are treated as individuals rather than as a couple from the point both are institutionalized (includes partial months). If only one member of the couple applied for Medicaid, the income and resources of the ineligible spouse was required to be deemed during the partial month.

Author: Audrey Middleton, Associate Director, Certification Support Division
Statutory Authority: 42 USC 1396r-5. Social Security Act, Section 1924 (a) through (g).
History: Permanent rule effective September 9, 1998. **Amended:** August 22, 2005; effective November 16, 2005.

Rule No. 560-X-25-.17. Low Income Subsidy (LIS).

(1) *The Medicare Prescription Drug, Improvement and Modernization Act of* 2003 (MMA), established the Medicare Prescription Drug Program, also known as Medicare Part D, making prescription drug coverage available to Medicare beneficiaries. The MMA also provides extra help in the form of a Low-Income Subsidy (LIS) to apply to the premium cost associated with Medicare Part D. Individuals qualifying for LIS will receive full or partial assistance with the monthly Medicare Part-D premium, the yearly deductible, and prescription co-payments depending on the income, family size, and resources of the beneficiary.

(2) Medicare beneficiaries with full Medicaid, SSI recipients, and Medicare beneficiaries participating in the Medicare Savings Programs (QMB, SLMB, QI) will be deemed to be eligible for LIS, and do not have to make a separate application. Medicare beneficiaries with limited income and resources who do not fall into one of the deemed subsidy groups must make application for the LIS Program through the Social Security Administration or the Medicaid Agency. If an individual or couple completes the Social Security Administration's LIS application at a Medicaid site, or forwards a completed Social Security Administration LIS application to a Medicaid site, the Medicaid Agency will forward the completed application to the Social Security Administration's LIS processing center. If an applicant insists upon a formal

LIS determination by Medicaid, the applicant must complete a Medicaid LIS application and submit the required verification to the Medicaid Agency.

(3) Individuals must be entitled to Medicare Part A (Hospital Insurance) and/or Part B (Medicare Insurance) and enroll in a prescription drug plan that services their area.

2006 Subsidy Eligible Groups

FPL & Assets	**Percentage of Premium Subsidy Amount (1)**	**Deductible**	**Copayment up to out of-pocket limit**	**Copayment above out of-pocket limit**
Full-benefit dual eligible individual – institutionalized individual	100%*	$0	$0	$0
Full-benefit dual eligible individual – Income at or below 100% FPL (non-institutionalized individual)	100%*	$0	The lesser of: (1) an amount that does not exceed $1- generic/ preferred multiple source and $3- other drugs, or (2) the amount charged to other individuals below 135% FPL and with assets that do not exceed $6,000 (individuals) or $9,000 (couples)	$0
Full-benefit dual eligible individual – Income above 100% FPL (non-institutionalized individual)	100%*	$0	An amount that does not exceed $2- generic/preferred multiple source and $5-other drugs	$0
Other low-income beneficiary with income below 135% FPL and with assets that do not exceed	100%*	$0	An amount that does not exceed $2- generic/preferred multiple source	$0

$6,000 (individuals) or $9,000 (couples)			and $5-other drugs	
Other low-income beneficiary with income below 135% FPL and with assets that exceed $6,000 but do not exceed $10,000 (individuals) or with assets that exceed $9,000 but do not exceed $20,000 (couples)	100%*	$50	15% coinsurance	An amount that does not exceed $2-generic/ preferred multiple source drug or $5-other drugs
Other low-income beneficiary with income at or above 135% FPL but below 150% FPL, and with assets that do not exceed $10,000 (individuals) or $20,000 (couples)	Sliding scale premium subsidy (100%-0%)	$50	15% coinsurance	An amount that does not exceed $2-generic/ preferred multiple source drug or $5-other drugs

(4) The following eligibility criteria must be met:

(a) Resource limits are effective using SSI criteria

1. Individual at or below $10,000 plus $1,500 burial exclusion

2 Couples at or below $20,000 plus $3,000 burial exclusion

(b) Income limits are effective using SSI criteria

1. Full subsidy - income at or below 135% of the FPL

2. Partial subsidy - income above 135% but below 150% of the FPL

(c) Poverty level standards for income will be based on household size which will include the applicant, his/her spouse, and all relatives for whom the applicant provides support and could claim for income tax purposes, and who are living with the applicant.

(d) Income and resources will be verified

(e) Reviewed annually

(5) LIS eligibility is as follows:

(a) For calendar year 2006, eligibility is effective as of the first day of the month of application, but not earlier than January 1, 2006, and remains in effect for a period not to exceed one year.

(b) For any calendar year after 2006, eligibility is effective as of the first day of the month of application and remains in effect for a period consistent with the State Plan, but not to exceed one year.

(c) LIS determination is not a determination for eligibility for Medicaid services.

(d) LIS is subject to Medicaid administrative rules and policies regarding application processing and redeterminations

Author: Audrey Middleton, Associate Director, Policy and Program Implementation Unit, Certification Support Division
Statutory Authority: Social Security Act 1935(a), 1860D-14, 1905(p)(3); and 42 CFR 423.774 and 423.904.
History: New Rule Filed: November 18, 2005; effective February 15, 2006.

Chapter 26. Rules of Practice Before Agency

Rule No. 560-X-26-.01. Rules of Practice Before Agency.

1. Any properly authorized person over 18 years of age may practice before the Agency. This includes, but is not limited to:
   - (a) Attorneys
   - (b) Accountants
   - (c) Officers or employees of a provider
   - (d) An adult friend or relative of a recipient or applicant.
   - (e) The Legal Guardian of a recipient or applicant.
2. While the agency will permit any person of legal age to represent any other person before the Agency, the Agency cautions that fair hearings by law, must be conducted according to the rules of evidence used in civil courts in non-jury cases.

Authority: Code of Alabama Section 41-22-4(a)(2). Rule effective October 1, 1982.

Rule No. 560-X-26-.02. Authority of Representative.

Any person appearing on behalf of another must have written authority to do so. If the person being represented is unable to sign an authorization, it must be signed by his or her Legal Guardian, if there is one, or if there is none, then by a member of his or her immediate family, preferably his or her sponsor. A form for this purpose is available from the Medicaid Agency. It is entitled "Appointment of Representative". A copy is contained in Chapter 28 of this code. While use of that form is preferred, the agency will accept any typed or written authorization and appointment notice that: (1) expressly authorized the representative to receive notices in the person's stead; (2) expressly authorizes the receipt of confidential Medicaid information; (3) contains the person's typed or printed name and Medicaid number (or Social Security number, if there is no Medicaid number).

Authority: Code of Alabama, Section 41-22-4(a)(2). Rule effective October 1, 1982.

Rule No. 560-X-26-.03. Practice by Suspended Representative.

Any attorney or public accountant who is under suspension or revocation of his or her license shall not represent any person before the Agency, except members of his or her immediate family, unless and until his or her license is restored.

Authority: Code of Alabama, Section 41-22-4(a)(2). Rule effective October 1, 1982.

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Chapter 27. Confidential Materials

Rule No. 560-X-27-.01. Confidential Materials-Applicant and Recipient Data.

(1) Information regarding Medicaid applicants and recipients is required to be safeguarded by Section 1902(a)(7) of the Social Security Act (SSA), 42 CFR Part 431, Subpart F, the Health Insurance Portability and Accountability Act (HIPAA), and 45 CFR Part 164. Confidential materials or categories of information relating to Medicaid applicants and recipients include, but are not limited to, the following:

(a) Lists of names, addresses, and Medicaid eligibility numbers;
(b) Medical services provided;
(c) Social and economic conditions and circumstances;
(d) Medicaid or other State or Federal government agency evaluation of personal information;
(e) Medicaid data, including but not limited to, diagnosis and past history or disease or disability;
(f) Fair hearing records.

(2) Confidential information relating to applicants and recipients may be used or disclosed only for purposes directly connected with the administration of the State Plan and in accordance with the Agency HIPAA Privacy Compliance Manual or other appropriate authority.

Author: Bill Butler, General Counsel
Statutory Authority: Code of Alabama, Section 41-22-12; Social Security Act §1902(a)(7); State Plan §4.3; 42 CFR §431.300, et seq.; and 45 CFR §164.102, et seq.
History: Rule effective October 1, 1982. Emergency rule effective April 5, 1985. Amended July 9, 1985. Emergency rule effective November 16, 1987. Amended February 9, 1988. **Amended:** Filed March 22, 2004; effective June 16, 2004.

Rule No. 560-X-27-.02. Confidential Materials - Other Items.

(1) The following materials or categories of information are declared to be confidential and the same shall not be released to persons outside the Medicaid Agency except as noted below:

(a) Minutes of the Utilization Review Committee (URC);
(b) Claims Processing Manual;
(c) Personnel records of agency personnel;
(d) Any communications, documents or materials by and between Agency legal counsel and Medicaid Agency personnel which come within the protection of the attorney-client privilege under the common law of Alabama.

(2) Confidential materials referred to in Paragraphs (1)(a), (b) and (c) may be released to persons outside the Medicaid Agency only as follows:

(a) In response to a valid subpoena or court order;
(b) To State or Federal auditors, on a need-to-know basis.
(c) With regard to URC minutes, a redacted version which deletes information about third persons may be released to the affected recipient, provider or authorized representative.

(3) Confidential materials referred to in Paragraph (1)(d) shall not be released except by court order.

(4) These confidential materials may be released in other situations in which a need-to-know is demonstrated, if not otherwise prohibited by law and if authorized by the Commissioner, Deputy Commissioners or the Agency General Counsel.

Author: Bill Butler, General Counsel
Statutory Authority: Social Security Act §1902(a)(7); State Plan §4.3; 42 CFR §431.300, et seq.; and 45 CFR §164.102, et seq.
History: Rule effective October 1, 1982. **Amended:** Filed March 22, 2004; effective June 16, 2004.

Chapter 28. Forms Used by Agency

Rule No. 560-X-28-.01. Forms.

The following forms are presented as reference and to illustrate examples of each of the official forms referred to within the rules contained in the Alabama Medicaid Agency Administrative Code.

1. Plastic Identification Card.
2. Medicaid Monthly Eligibility Care (Social Security SSI Medicaid Certified Eligibles).
3. Examples of Termination Notices.
4. Alabama Medicaid RESTRICTED Eligibility Card.
5. Alabama Medicaid Recipient Restriction-Provider Notice.
6. Alabama Medicaid Recipient Restriction (Medical Referral of Restricted Recipient).
7. Certification and Documentation for Abortion.
8. Hysterectomy Consent Form PHY-81243 (rev. 05/20/82).
9. Sterilization Consent Form.
10. Form XIX-TPD-1-76, Medicaid Authorization Assignment.
11. Form HEW-641 (5/77).
12. Form HCFA-1561 (4/80).
13. Form XIX-HHC-DME-1. (Rev. 09/84).
14. Form XIX-SDT-3-72.
15. HCFA-1500 (1-84).
16. AlaMed 82-1, Revised 6-85, Appointment of Representative.
17. AlaMed 82-2, Petition for a Declaratory Ruling.
18. AlaMed 82-3, Petition for a Rule Change.
19. Form LTC-2 (Revised 8/86).
20. Form XIX-LTC-3 Revised 6/92.
21. Form XIX-LTC-4 (rev. 82).
22. Form XIX-LTC-10 (Revised 4/94).
23. Form XIX-LTC-1 (rev. 82).
24. Form XIX-LTC-9 (rev. 2-84).
25. Reserved
26. AlaMed 82-4, Lien For Medical Payments Under Alabama Medicaid Program.
27. Referral and Treatment Plan, XIX-HHC-1-70 (Rev. 3/81).
28. Medicaid Home Health Start of Care Sheet, (SOC-1).
29. Medicaid Home Health Recertification, XIX-HHC-1-70-A (Rev. 10/81).
30. Medicaid Home Health Claim Form, MCD-6.
31. Medicaid Claim Inquiry.
32. Medicaid Monthly Eligibility Card for Recipients Enrolled in a Health Maintenance Organization.
33. UB-82
34. Eligibility Inquiry, MED-400.

Authority: Alabama Medicaid Agency Administrative Code. Rule effective October 1, 1982. Amended January 8, 1986; December 18, 1986; April 14, 1987; July 10, 1987, September 9, 1987; February 9, 1988, and May 10, 1988. Emergency rule effective June 17, 1988. Amended October 12, 1988. Emergency Rule effective October 7, 1988. Effective date of amendment January 10, 1989. Amended July 13, 1991. Effective date of this amendment March 13, 1992. Effective date of this amendment is November 12, 1992. Effective date of this amendment August 12, 1994.

Rule No. 560-X-28-.02 Summary of State Law Regarding Advanced Directives New Rule.

Deciding about your health care

If you are 19 or older, the law says you have the right to decide about your medical care.

If you are very sick or badly hurt, you may not be able to say what medical care you want.

If you have an advance directive, your doctor and family will know what medical care you want if you are too sick or hurt to talk or make decisions.

What is an advance directive?

An advance directive is used to tell your doctor and family what kind of medical care you want if you are too sick or hurt to talk or make decisions. If you do not have one, certain members of your family will have to decide on your care.

You must be at least 19 years old to set up an advance directive. You must be able to think clearly and make decisions for yourself when you set it up. You do not need a lawyer to set one up, but you may want to talk with a lawyer before you take this important step. Whether or not you have an advance directive, you have the same right to get the care you need.

Types of advance directives

In Alabama you can set up an Advance Directive for Health Care. The choices you have include:

A living will is used to write down ahead of time what kind of care you do or do not want if you are too sick to speak for yourself.

A proxy can be part of a living will. You can pick a proxy to speak for you and make the choices you would make if you could. If you pick a proxy, you should talk to that person ahead of time. Be sure that your proxy knows how you feel about different kinds of medical treatments.

Another way to pick a proxy is to sign a durable power of attorney for health care. The person you pick does not need to be a lawyer.

You can choose to have any or all of these three advance directives: Living will, proxy and/or durable power of attorney for health care.

Hospitals, home health agencies, hospices and nursing homes usually have forms you can fill out if you want to set up a living will, pick a proxy or set up a durable power of attorney for health care. If you have questions, you should ask your own lawyer or call your local Council on Aging for help.

When you set up an advance directive

Be sure and sign your name and write the date on any form or paper you fill out. Talk to your family and doctor now so they will know and understand your choices. Give them a copy of what you have signed. If you go to the hospital, give a copy of your advance directive to the person who admits you to the hospital.

What do I need to decide?

You will need to decide if you want treatments or machines that will make you live longer even if you will never get better. An example of this is a machine that breathes for you.

Some people do not want machines or treatments if they cannot get better. They may want food and water through a tube or pain medicine. With an advance directive, you decide what medical care you want.

Talk to your doctor and family now

The law says doctors, hospitals and nursing homes must do what you want or send you to another place that will. Before you set up an advance directive, talk to your doctor ahead of time. Find out if your doctor is willing to go along with your wishes. If your doctor does not feel he or she can carry out your wishes, you can ask to go to another doctor, hospital or nursing home.

Once you decide on the care you want or do not want, talk to your family. Explain why you want the care you have decided on. Find out if they are willing to let your wishes be carried out.

Family members do not always want to go along with an advance directive. This often happens when family members do not know about a patient's wishes ahead of time or if they are not sure about what has been decided. Talking with your family ahead of time can prevent this problem.

You can change your mind any time

As long as you can speak for yourself, you can change your mind any time about what you have written down. If you make changes, tear up your old papers and give copies of any new forms or changes to everyone who needs to know.

For help or more information:

Alabama Commission on Aging 1-800-243-5463

Choice in Dying 1-800-989-9455

Author: William O. Butler, III, General Counsel

Statutory Authority: Alabama Medicaid Agency Administrative Code; Title XIX, Social Security Act; and §41-22-1 et seq., Code of Ala. 1975.

History: Rule effective October 1, 1982, June 17, 1988, October 7, 1988, October 12, 1988, January 10, 1989, July 13, 1991, March 13, 1992, January 13, 1993, and May 13, 1994. Amended: Filed April 20, 1999; effective July 13, 1999.

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Chapter 29. Definitions of Terms Used in Rules

The following terms and definitions are presented as reference to accompany and clarify the rules contained in this Administrative Code of the Alabama Medicaid Agency.

(1) Provider - Provider shall mean an institution, facility, agency, person, partnership, corporation, or association which is approved and certified by Medicaid as authorized to provide the recipients the services specified in the plan at the time services are rendered.

(2) Recipient - Recipient shall mean a person who has been assigned one or more Medicaid identification numbers and has been certified by Medicaid as eligible for medical assistance under the State Plan.

(3) Claim - Claim shall mean all charges included in a single billing by a single provider for one type of service rendered to one recipient. Each prescription shall be considered one claim. On group claims, such as nursing home claims, each line item covering a period of service shall be considered a claim.

(4) Dental Services - Dental services are those services for recipients under 21 years of age which are necessary for relief of pain and infection, for restoration of teeth, and for maintenance of dental health and which are authorized by Medicaid.

(5) Emergency Services - Emergency services shall mean those medical services which are necessary to prevent the death or serious impairment of the health of a recipient and which, because of the threat to the life or health of the recipient, necessitates the use of the most accessible services available and equipped to furnish such services.

(6) Emergency Room Services - Emergency room services mean those services performed in an emergency room and in response to bona fide emergencies. A patient having coverage under Medicaid is entitled to have payment made on his behalf for outpatient hospital benefits which are medically necessary. Medicaid will only authorize payment for bona fide emergency treatment rendered in hospital emergency rooms. Any service rendered other than a bona fide emergency must state the type of outpatient service, and be so billed as an outpatient services(s).

(7) Eye care Services - Eye care services for the Medicaid Program are defined as those health care services requested by eligible recipients for eye examinations (as defined herein), including refraction and prescription for eyeglasses, if necessary, performed by physicians who are trained in eye examination procedures or by licensed optometrists, and the provision of eyeglasses, frames, or lenses by a firm under contract with Medicaid. If eyeglasses are required and provided, services will include verification of prescription, dispensing of eyeglasses (including laboratory selection), frame selection, procurement of eyeglasses and fitting and adjusting eyeglasses to the patient by the above mentioned physician and optometrists or by licensed opticians.

(8) Eye Examination - Eye examination is a complete eye examination, including the case history, eye health examination visual acuity testing, visual fields, if indicated, tonometry, refraction and prescribing of eye glasses, if indicated.

(9) Special Ophthalmic Services - Special ophthalmic services are orthoptics, eye examination for contact lenses following cataract surgery and such other eye care services authorized by Alabama Medicaid Agency when performed by a licensed physician (ophthalmologist) or optometrist.

(10) Home Health Care Services - Home health care services shall mean visits ordered by a physician authorized by Medicaid and provided to home bound recipients by licensed registered and practical nurse and nurses aides from authorized home health care agencies; and medical supplies, appliances, and items or durable medical equipment suitable for use in the home.

(11) Independent Laboratory and Radiology Services - Independent laboratory and radiology services are those services ordered by a physician or dentist, in connection with medical or dental services, and which are performed by a Medicare/Medicaid facility that operates primarily independent of a physician's office or other health care facility.

(12) Medical Supplies - Medical supplies, appliances, and equipment are those items listed in the Home Health Care Manual or specifically prior authorized for a recipient by Medicaid.

(13) Medicare - Medicare shall mean the program providing hospital and medical benefits under Title XVIII of the Social Security Act.

(14) Medicare Deductibles and Coinsurance - Medicare deductibles and coinsurance mean all charges classified as deductibles and/or coinsurance under Medicare Part A and/or Part B for all services authorized by Medicare Part A and/or Part B.

(15) Physician - Physician shall mean:

(a) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he renders services;

(b) A doctor of dentistry or of dental or oral surgery licensed to practice dentistry or dental or oral surgery by the state in which he renders services but only with respect to:

1. Surgery related to the jaw;
2. The reduction of any fracture relating to the jaw or facial bone;
3. Surgery within the oral cavity for removal of lesions or the correction of congenital defects;
4. Fabrication of a prosthesis for closure of a space within the oral cavity created by the removal of a lesion, or congenital defect such as cleft palate.

(16) Screening (Early and Periodic Screening, Diagnosis, and Treatment) - an unclothed physical examination using quick, simple procedures to sort out apparently well children from those who have a disease, condition or abnormality and to identify those who may need diagnosis, evaluation and/or treatment of their physical or mental problems. Refer to Chapter 11, EPSDT, for further information.

(17) Prescribed Drugs - Medicaid covers only legend and certain non-legend drugs of participating manufacturers which have entered into rebate agreements with Health and Human Services when the drugs are prescribed by licensed physicians or dentists for medically accepted conditions, and dispensed by contract Medicaid providers. Certain drugs may be excluded by federal law.

(18) Abuse - shall be considered to be any act or action taken by a recipient or provider which has a detrimental effect upon the Alabama Medicaid Program and which is not provided for or anticipated under the provisions of the Alabama Medicaid Program. The following examples shall constitute prima facie evidence, though not conclusive evidence, of abuse of the Alabama Medicaid Program:

(a) Failure to make any payment due Medicaid from any third party recovery.

(b) Having knowledge that an individual other than the authorized recipient, has used a Medicaid eligibility card to obtain benefits provided by the Alabama Medicaid Program and not reporting this unauthorized use to Medicaid within a reasonable period of time not to exceed 60 days;

(c) Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from Medicaid.

(d) Failure to repay identified over-payments or erroneous payments received from Medicaid.

(19) Misuse/Overutilization - is any act or action taken by a Medicaid recipient or provider which results in a recipient receiving services in excess of those normally required for the illness or malady suffered by the recipient and which results in unnecessary cost to the Alabama Medicaid Program. The following examples shall constitute prima facie evidence, though not conclusive evidence, of misuse of the Alabama Medicaid Program:

(a) A Medicaid recipient going to more than one doctor for treatment of the same illness when there is no justifiable medical reason for the recipient seeking services from more than one physician;

(b) A Medicaid recipient obtaining from more than one physician or from the same physician multiple prescriptions for the same drugs for the same period of consumption.

(c) A Medicaid recipient attempting to stockpile drugs by obtaining prescriptions for drugs for illnesses or conditions which the recipient is not suffering from or afflicted by;

(d) Charges by a provider in excess of reasonable and allowable costs.

(20) Fraud - Any Medicaid recipient or Medicaid recipient's sponsor or provider who knowingly, with intent to defraud or deceive, make or causes to be made any false statement or representation of a material fact in any application of claim for benefits or payment under the Alabama Medicaid Program. The following examples shall be prima facie evidence, though not conclusive evidence, of fraud:

(a) A Medicaid recipient, sponsor, or provider making a false statement or representation in any application for benefits or payment for benefits to a recipient under the Alabama Medicaid Program;

(b) A Medicaid recipient obtaining, or provider rendering, any service under the Alabama Medicaid Program by making false statement of the recipient's condition or illness while knowing such statement is false;

(c) A Medicaid recipient or sponsor obtaining drugs, supplies, or any durable item provided under the Alabama Medicaid Program not for his or her own benefits but with the intent to sell the same item for a valuable consideration.

(d) A Medicaid recipient allowing his or her eligibility card to be used by someone else with the knowledge that the other individuals intends to obtain benefits provided by the Alabama Medicaid Program.

(21) Peer - A person or committee in the same health care profession as the provider whose Medicaid practices are being reviewed.

(22) Peer Review - An activity performed by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally accepted standards.

(23) Recoupment - The procedure of obtaining repayment of an equivalent overpayment received from the Medicaid program by a provider or recipient. Procedure could include withholding payments for claims being processed.

(24) REOMB - Recipient Explanation of Medical Benefits, a Medicaid Management Information System requirement for recipient to verify services received.

(25) Restitution - The procedure of reimbursement by a provider or recipient to the Medicaid program for payments and/or benefits wrongfully received.

(26) Suspension from Participation - Exclusion from participation in the Medicaid program for a specified period of time.

(27) Termination from Participation - a permanent exclusion from participation in the Medicaid program.

(28) Utilization Review - A procedure to assure that services provided are commensurate with the patient's medical conditions. This includes reviewing quality of care, medical necessity, and scope of services.

(29) Withholding of Payments - A reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purpose of offsetting overpayments previously made to the provider.

(30) Place of Residence - A patient's residence is wherever he/she makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. Hospitals, nursing homes or extended care facilities may not be considered his/her residence for purpose of home health coverage.

(31) Health Maintenance Organization - An organization which provides, either directly or through contractual arrangements, health care services, medical assistance, and rehabilitative services which enrollees might reasonably require to be maintained in good health. Payment for such services shall be made on a capitation basis.

(32) Unstable Medical Condition – One in which there is documentation of an episode of acute illness or exacerbation of a diagnosis which requires active treatment in the 60 days prior to the admission date into a Medicaid program. The provider must have supporting documentation of the acute illness or exacerbation and active treatment.

(33) Chronic Stable Medical Condition – A condition that has persisted over six months and clinical documentation supports that there has been no significant changes in the past 60 days or in the 60 day period prior to admission into a Medicaid program.

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; 42 CFR Section 401, et seq.
History: Rule effective October 1, 1982. Effective date of this amendment is May 13, 1992. **Amended:** Filed November 17, 2006; effective February 15, 2007.

Chapter 30. Emergency Rule Procedures

Rule No. 560-X-30-.01. Emergency Rule Procedures.

1. The Commissioner, upon an express finding or determination that there exists an immediate danger to the public health, safety, or welfare, requires adoption of a rule upon fewer than 35 days' notice or that action is required by or to comply with a federal statute or regulation which requires adoption of a rule upon fewer than 35 days' notice and states in writing his reasons for that finding may proceed without prior notice or hearing to adopt an emergency rule.
2. An Emergency Rule may be effective for up to 120 days. The Emergency Rule shall state its effective dates, both beginning and ending.

Authority: Code of Alabama Section 41-22-5. Rule effective October 1, 1982.

Rule No. 560-X-30-.02. Permanent Rule After Emergency Rule.

During the period that an Emergency Rule is in effect the Agency shall give notice of and promulgate a permanent rule to replace the Emergency Rule, unless the Emergency Rule is one designed to fill a specific need or to solve a specific problem and that need or problem is not expected to reoccur.

Authority: Code of Alabama Section 41-22-5(b). Rule effective October 1, 1982.

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Chapter 31. Declaratory Rulings

Rule No. 560-X-31-.01. Declaratory Rulings.

1. Any person or organization affected by an existing rule or statute governing the Alabama Medicaid program may request a Declaratory Ruling.
2. The Petition for Declaratory Ruling form found in Chapter 28 must be used. Copies are available from the Agency.
3. If a petition cannot be acted upon within 45 days of its receipt by the agency, the petition may be deemed denied as provided by Section 41-22-11 (b) of the Code of Alabama, or the petitioner may agree to an extension in order to obtain a ruling. The Agency will advise the petitioner if an extension would aid the Agency. The petitioner need not agree to the extension, but may if a ruling is desired.

Authority: Code of Alabama, Section 41-22-11. Rule effective October 1,1982.

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Chapter 32. Rules Adopted by Reference (CPT32.R)

Rule No. 560-X-32-.01. Rules Adopted by Reference.

The provisions of Title 42 of the Code of Federal Regulations relating to the Medicaid Program; the Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act; as all of the same may be amended are hereby adopted by reference as a part of this code.

Authority: Code of Alabama, Section 41-22-9. Rule effective October 1, 1982.

Rule No. 560-X-32-.02. Petitions for Adoption, Repeal, or Change of a Rule.

1. A form for petitioning for a new rule, for the repeal of an existing rule, and for the change or modification of a rule is included in Chapter 28. This form must be used. Copies are available from the Agency.
2. Action on such a petition shall be within 60 days of receipt by the Agency.

Authority: Code of Alabama, Section 41-22-8. Rule effective October 1, 1982.

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Chapter 33. Recoupments and Liens

Rule No. 560-X-33-.01. General.

Federal regulations require that the State make provisions for handling of recoupments and recoveries. The Alabama Medicaid Agency will actively seek recovery of all misspent Medicaid funds and correctly paid benefits recoverable under Federal law.

Authority: Social Security Act; State Plan; Alabama Code, Section 22-1-11, Section 22-6-8, and Section 35-1-2; 42 C.F.R. Part 431, Parts 450 and 455; 45 C.F.R. Part 205; 45 C.F.R. Part 233.

Rule No. 560-X-33-.02. Purpose.

The purpose of the recoupments, recoveries and liens effort is to assure that the State and Federal dollars allocated for medical assistance are spent only on those individuals who meet all eligibility criteria; to correct erroneous payments; and to recover benefits correctly paid, but recoverable by law. This mission will be fulfilled through solicitation of voluntary reimbursement and administrative and legal remedies in keeping with limitations set by Federal guidelines.

Authority: Social Security Act, Title XIX; State Plan; 42 C.F.R. Parts 450 and 455. Rule effective October 1, 1982.

Rule No. 560-X-33-.03 Methods.

Recoupment by the Alabama Medicaid Agency will be carried out using administrative procedures and civil and criminal proceedings to ensure that erroneous Medicaid payments are reimbursed and recoverable payments are collected. The methods may include but will not be limited to:

1. Direct reimbursement by the recipient or his sponsor to the Alabama Medicaid Agency.
2. Time payment by the recipient or by the sponsor on behalf of the recipient (if terms are acceptable to the Agency).
3. Recovery of erroneous payments to providers through the fiscal agent from monies due those providers (to be used under special circumstances).
4. Liens upon real property of recipients for recoverable benefits as permitted by Federal law.
5. Administrative sanctions on cases involving fraud or abuse of the Medicaid Program.
6. Civil actions through the courts as deemed appropriate and approved by the Attorney General.

Authority: Social Security Act, Title XIX; State Plan; 42 C.F.R. Parts 450 and 455; Alabama Code, Section 35-1-2, Section 22-6-8, Section 22-1-11; 45 C.F.R. Part 233, 45 C.F.R. Part 302.

Rule No. 560-X-33-.04 Procedures.

1. Direct reimbursement

   At the time of original identification of the expected amount of recoupment, a letter will be sent to the recipient/sponsor outlining the allegations and stating the amount of reimbursement and the specific dates when overpayment or recoverable benefits occurred. The recipient/sponsor will be offered the opportunity to present evidence to rebut the requirement for recoupment or to submit the reimbursement. If no rebuttal is offered, the original assessment will be presumed correct. Legal proceedings will be initiated in the event reimbursement is not received.

2. Time Payment Plan

   The reimbursement amount is due immediately. Upon sufficient justification, Alabama Medicaid Agency may allow a time payment plan. Under no circumstances will such payment schedule exceed two years.

3. Fiscal Agent Recoupment

   In the event the provider is the payee for the recipient (in effect, the sponsor) and has received the monies to be recouped, the excess payment will be withheld from the next adjustment payroll by the fiscal agent.

4. Liens upon real property of recipients.

   Liens will be placed upon and foreclosed upon real property of recipients and deceased recipients to the extent allowed by 42 USC Section 1396(a)(18) and 42 C.F.R. Section 433.36.

   (a) Where benefits have been incorrectly paid to or on behalf of a present or former recipient, the Agency after obtaining the concurrence of the Attorney General, may institute appropriate legal proceedings to obtain a judgement lien against that recipient of former recipient's property or estate; such liens will thereafter be enforced according to law.

   (b) In the case of an individual who has received or is applying to receive benefits that are correctly paid due to the individual's being entitled to a temporary property or resource exclusion under the Agency's eligibility rule, the Agency may require said recipient to grant the Agency a lien by recording the same and, when appropriate, after obtaining the concurrence of the Attorney General, institute appropriate legal proceedings to obtain a judgement lien against that individual's property. Such lien may be obtained and secured by execution of a document substantially like Exhibit A, attached. (See Chapter 28 for a copy of the form to be used.) Such liens will become due, payable, and enforceable upon sale or transfer of lease for more than one year of said property, or upon death of grantor, and will otherwise be enforced in accordance with the provisions of 42 USC Section 1396(a)(18) as same may be amended by the Congress of the United States.

   (c) The Agency may file claims against the estate of a deceased recipient who received benefits incorrectly, in accordance with existing law.

   (d) The Agency may file a claim against the estate of a deceased recipient who correctly received benefits after the recipient was over 65 years of age (where the recipient's eligibility under Agency rules was due to a temporary property or resource exclusion). Enforcement of such claims will be subject to the provisions of 42 USC Section 1396(a)(18) as same may be amended by the Congress of the United States.

   (e) If a recipient described in Paragraph (3) and

5. above dies intestate or is believed by the Agency to have died intestate, the Agency, after obtaining the concurrence of the Attorney General, in order to protect its right to file a claim against the deceased recipient's estate, may file a petition for letters of administration in situations where the Agency's claim warrants the expense of administering the estate.

6. Administrative sanctions.

   Cases involving apparent fraud and abuse of the Medicaid Program may be corrected with administrative sanctions within Federal guidelines. Such sanctions may involve one or more years ineligibility from the Medicaid Program and until full restitution has been made.

7. Civil Actions

   Civil actions through the courts may be initiated on cases where the above procedures have not resulted in a satisfactory resolution.

8. Criminal Actions

   If there are strong indications of fraud and/or abuse of the Medicaid Program, cases will be referred to the appropriate authorities for prosecution.

Authority: Social Security Act, Title XIX; State Plan; Alabama Code, Section 22-1-11, Section 22-6-8, Section 35-1-2; 42 C.F.R. Parts 450 and 455; 45 C.F.R. Parts 233 and 302; 42 C.F.R. Section 401, et seq. Rule effective October 1, 1982. Effective date of amendment April 15, 1983.

Rule No. 560-X-33-.05. Appeals.

Any person aggrieved by a proposed or actual recoupment action that is directed at that person can have the same reviewed through the Agency's fair hearing procedures if the matter has not previously been the subject of a Fair Hearing. A hearing must be requested within 60 days of the date of the notice of the recoupment action. A recoupment action will not be abated during the time for requesting a hearing. The Agency may at its discretion suspend a recoupment action until after a hearing is held.

Authority: 42 C.F.R. Section 401, et. seq.; State Plan; Social Security Act, Title XIX. Rule effective October 1, 1982.

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Chapter 34. Independent Radiology Services

Rule No. 560-X-34-.01. Independent Radiology Services – General.

The Alabama Medicaid Agency will pay for services provided by independent radiology facilities that are enrolled by contract under the following conditions:

(a) The services must be medically necessary.
(b) The patient must be eligible for Medicaid at the time the services are rendered.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30. Rule effective October 13, 1998.

Rule No. 560-X-34-.02. Covered Services.

Radiology services are professional and technical radiological services – (a) ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law; (b) provided in an office or similar facility other than a hospital outpatient department or clinic; and (c) provided by a radiology facility that meets the requirements for participation in Medicare.

Radiology services are restricted to those that are described by procedures in the CPT manual (70010-79999) or one of the locally assigned HCPCS codes used only by Medicaid to supplement the listing in the CPT manual.

(a) Providers will be paid only for covered services which they are certified to perform and which they actually perform.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30. Rule effective October 13, 1998.

Rule No. 560-X-34-.03. Participation Requirements.

Independent radiology facilities must meet the following requirements for participation in the Alabama Medicaid Program:

(a) Be certified for participation with Medicare.
(b) Be independent of any hospital, clinic, or physician's office.
(c) Be licensed in the state where located, when it is required by that state.
(d) Submit to routine audits by Medicaid.
(e) Complete an application with all required attachments.
(f) Sign a provider agreement.
(g) Sign a Direct Deposit Authorization.
(h) Sign a Civil Rights Statement of Compliance.
(i) Effective date of enrollment will be the date of Medicare certification. However, providers who request enrollment more than 120 days after certification will be enrolled on the first day of the month the request for enrollment is received.

Author: Ginger Collum, Program Manager, Clinic/Ancillary Services

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30, 493.2.
History: Rule effective October 13, 1998. Amended: Filed December 17, 2001, effective March 15, 2002.

Rule No. 560-X-34-.04. Claims Filing Instructions.

(1) For time limits on claims submission, refer to the Radiology Services Billing Manual.

(2) Claims for radiology services must contain a valid diagnosis code.

(3) Claims submitted must contain the provider number of the radiology facility that actually performed the service. Claims must not be submitted using any other provider's number, such as the provider number of the referring physician or hospital.

(4) Claims containing fragmentation of radiology services may be recouped through postpayment review.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30, 493.2. Rule effective October 13, 1998.

Rule No. 560-X-34-.05. Third Party Payment Procedures.

For guidelines on submitting claims to Medicaid when a third party is involved, refer to the Radiology Services Billing Manual.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. Rule effective October 13, 1998.

Rule No. 560-X-34-.06. Sending Bills and Statements to Medicaid Recipients.

(1) Providers should not send recipients bills or statements for covered services once the recipient has been accepted as a Medicaid patient.

(2) Providers may send a notice to the recipient stating their claim is still outstanding if the notice indicates in bold letters, "**THIS IS NOT A BILL**".

(3) Providers are responsible for follow-up with the fiscal agent or Medicaid on any billing problems or unpaid claims.

(4) Providers agree to accept the amount paid by Medicaid as payment in full.

(5) Recipients are not responsible for the difference between charges billed and the amount paid by Medicaid for covered services.

(6) Recipients may be billed only for the allowable copayment amount, for services not covered by Medicaid, or when benefits have been exhausted.

(7) Providers may not deny services to any eligible recipient due to the recipient's inability to pay the allowable copayment amount.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.15, 447.50, 447.55. Rule effective October 13, 1998

Rule No. 560-X-34-.07. Prior Authorization

(1) Prior authorization is required for certain radiology codes. The performing provider (facility) or the referring/ordering provider may request prior authorization. Prior authorization requests must be made prior to the test being performed. In the event of an urgent situation (when the prior authorization cannot be obtained before the test is performed), a PA may be requested within 14 days from the date of service. The case must then meet the "urgent" criteria before it will be considered for review. Providers are allowed 30 days from the date of service to submit a request to change or add a code to an approved case.

(2) If a request is denied, written notice will be sent to the provider and the recipient indicating the reason for denial. Information giving them their right to appeal is also included in this notice.

(3) For further information regarding prior authorization for radiology procedures refer to Chapter 22 (Independent Radiology) of the Alabama Medicaid Provider Billing Manual.

Author: Teresa Thomas, Program Manager, Lab and X-Ray Services
Statutory Authority: State Plan 3.1-A; Title XIX, Social Security Act; 42 C.F.R. Section 440.30.
History: New Rule filed December 18, 2009; effective March 18, 2010.

Chapter 35. Home and Community-Based Waiver for Persons with Mental Retardation.

Rule No. 560-X-35-.01. Authority and Purpose.

(1) Home and community-based services for persons with mental retardation are provided by the Alabama Medicaid Agency to persons who are Medicaid-eligible under the waiver and who would, but for the provision of such services, require the level of care available in an intermediate care facility for the mentally retarded. These services are provided through a Medicaid waiver under provisions of the Omnibus Budget Reconciliation Act of 1981, which added Section 1915(c) to the Social Security Act for an initial period of three years and renewal periods of five years.

(2) Home and community-based services covered in this waiver are Residential Habilitation Training, Residential Habilitation-Other Living Arrangement, Day Habilitation, Prevocational Services, Supported Employment, Occupational Therapy Services, Speech and Language Therapy, Physical Therapy, Behavior Therapy, Companion Services, Respite Care, Personal Care, Environmental Accessibility Adaptations, Medical Supplies, Skilled Nursing, Assistive Technology, Crisis Intervention, and Community Specialist. These services provide assistance necessary to ensure optimal functioning of the mentally retarded or persons with related conditions.

(3) The Home and Community Based Waiver is administered with a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and Mental Retardation. Waiver services are limited to individuals with a diagnosis of mental retardation or related condition, age 3 and above.

Author: Laura Walcott, Administrator, LTC Program Management Unit
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended**: November 18, 1987 and January 14, 1997. **Amended**: Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed October 21, 2004; effective January 14, 2005. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-35-.02. Description of Services.

Home and Community-Based Services (HCBS) are defined as Title XIX Medicaid-funded services provided to mentally retarded individuals or persons with related conditions who, without these services, would require services in an ICF/MR. These services will provide health, social, and related support needed to ensure optimal functioning of the mentally retarded individual within a community setting. The administering agency may provide or subcontract for any services provided in this waiver. To qualify for Medicaid reimbursement each individual service must be

necessary to prevent institutionalization. Each provider of services must have a signed provider contract, meet provider qualifications and comply with all applicable state and federal laws and regulations. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as waiver services. The specific services available as part of Home and Community-Based services are:

(1) Residential Habilitation Training

(a) Residential habilitation training provides intensive habilitation training including training in personal, social, community living, and basic life skills.

(b) Staff may provide assistance/training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming and cleanliness.

(c) This service includes social and adaptive skill building activities such as expressive therapy, the prescribed use of art, music, drama, and/or movement to modify ineffective learning patterns, and/or influence changes in behavior recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities.

(d) The cost to transport individuals to activities such as day programs, social events or community activities when public transportation and/or transportation services covered under the State Plan are not available, accessible or desirable due to the functional limitations of the recipient will be included in the rate paid to providers for this service.

(e) Residential Habilitation Training services may be delivered/supervised by a Qualified Mental Retardation Professional (QMRP) in accordance with the individual's plan of care.

(f) Residential Habilitation Training services can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a Qualified Mental Retardation Professional.

(g) A Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the Department of Mental Health/Mental Retardation. Retraining will be conducted as needed, at least annually.

(2) Residential Habilitation - Other Living Arrangement (OLA)

(a) Residential habilitation training in other living arrangements is a service in which recipients reside in integrated living arrangements such as their own apartments or homes. These services shall be delivered in the context of routine day-to-day living rather than in isolated "training programs" that dictate the individual transfers what is learned to more relevant applications. Habilitation may range from a situation where a staff member resides on the premises to those situations with staff monitoring of clients served at periodic intervals. The basic concept of this service is that learning to be independent is best accomplished for some individuals by living independently.

(b) The staff may provide assistance/training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming and cleanliness.

(c) This service includes social and adaptive skill building activities such as expressive therapy, the prescribed use of art, music, drama, or movement to modify ineffective learning patterns, and/or influence changes in behavior, recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities.

(d) Residential habilitation training services for individuals in other living arrangements may be delivered/supervised by a QMRP in accordance with the individual's plan of care.

(e) Residential habilitation training can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QMRP.

(f) A Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the Department of Mental Health/Mental Retardation. Retraining will be conducted as needed, but at least annually.

(g) The cost to transport individuals to activities such as day programs, social events or community activities when public transportation and/or transportation services covered under the State Plan are not available, accessible or desirable due to the functional limitations of the client will be included in the rate paid to providers for this service.

(3) Day Habilitation

(a) Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides.

(b) The provider for Day Habilitation services can be reimbursed based on eight levels of services.

(c) Services shall normally be furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the recipient's plan of care. Day Habilitation services shall focus on enabling the individual to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care.

(d) Transportation cost associated with transporting individuals to places such as day programs, social events or community activities when public transportation and/or transportation covered under the State Plan is not available, accessible or desirable due to the functional limitations of the recipient will be included in the rate paid to providers for this service. Day Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service. Providers of day habilitation must be certified by the Department of Mental Health and Mental Retardation.

(4) Prevocational Services

(a) Prevocational services are not available to recipients for eligible benefits under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Education of the Handicapped Act.

1. Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job task oriented.

2. Prevocational services include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

3. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

4. When compensated, individuals are paid at a rate of less than 50 percent of the minimum wage.

(5) Supported Employment

(a) Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

1. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed.

2. Supported employment also includes activities needed to sustain paid employment by waiver clients, including supervision and training.

3. When supported employment services are provided at a work site in which persons with disabilities are employed, payment will be made only for the adaptations, supervision and training required by waiver recipients as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business settings.

4. Supported employment may be provided under the Individual Job Coach and Job Development services to further encourage full integration of waiver participants into worksites where individuals without disabilities are employed.

5. Supported employment services are not available to recipients eligible for benefits under a program funded by either Section 110 of the Rehabilitation Act of 1973, or Section 602 (16) and (17) of the Education of the Handicapped Act.

6. Transportation will be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

(6) Occupational Therapy Services.

(a) Occupational therapy services include the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure and/or obtain necessary function.

(b) Therapists may also provide consultation and training to staff or caregivers (such as recipient's family and/or foster family).

(c) Services must be prescribed by a physician and provided on an individual basis. The need for service must be documented in the case record. Services must be listed on the care plan, provided and billed in 15 minute increments. Occupational therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(7) Speech and Language Therapy

(a) Speech and language therapy services include screening and evaluation of individuals with speech and hearing impairments.

1. Comprehensive speech and language therapy is prescribed when indicated by screening results.

(b) This service provides treatment for individuals who require speech improvement and speech education. These are specialized programs designed for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.

(c) Therapists may also provide training to staff and caregivers (such as a recipient's family and/or foster family).

(8) Physical Therapy

(a) Physical therapy includes services which assist in the determination of an individual's level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs.

1. Such services preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living.

2. This service also helps with progressive disabilities through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

(b) Physical Therapists may also provide consultation and training to staff or caregivers (such as recipient's family and/or foster family).

(9) Behavior Therapy

(a) Behavior therapy services provide~~s~~ systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self direction or community integration~~s~~, whose health is at risk, and/or who may otherwise require movement to a more restrictive environment. Behavior therapy may include consultation provided to families, other caretakers, and habilitation services providers. Behavior therapy shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior.

(b) A behavior support plan may only be used after positive behavioral approaches have been tried, and its continued use must be reviewed and rejustified in the case record every thirty (30) days. The unit of service is 15 minutes.

(c) The Behavior Therapy waiver service is comprised of two general categories of service tasks. These are (1) development of a BSP and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

(d) The two professional service provider levels are distinguished by the qualifications of the therapist. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform behavior therapy tasks. There is a different code and rate for each of the three service provider levels.

(e) Providers of service must maintain a service log that documents specific days on which services are delivered. Group therapy will not be reimbursed.

(f) The maximum units of service per year of both professional and technician level units combined cannot exceed 600 and the maximum units of service of professional level cannot exceed 400.

(10) Companion Services

(a) Companion services are non-medical supervision and socialization, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, and shopping, but may not perform these activities as discrete services.

1. The provision of companion services does not entail hands-on medical care.
2. Companions may perform light housekeeping tasks which are incidental to the care and supervision of the recipient.
3. This service is provided in accordance with a therapeutic goal in the plan of care and is not merely diversional in nature.
4. This service must be necessary to prevent institutionalization of the recipient.

(11) Respite Care

(a) Respite care is given to individuals unable to care for themselves on a short term basis because of the absence or need for relief of those persons normally providing the care. Respite care may be provided in the recipient's home, place of residence, or a facility approved by the State which is not a private residence.

(b) Respite care may be provided up to a maximum of 1080 hours or 45 days per waiver year.

(c) This service cannot be provided by a family member.

(d) Out-of-home respite care may be provided in a certified group home or ICF/MR. In addition, if the recipient is less than 21 years of age, out-of-home respite care may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out-of-home respite, no additional Medicaid reimbursement will be made for other services in the institution.

(e) Medicaid reimbursement shall not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

(12) Personal Care

(a) Personal care services are services provided to assist residents with activities of daily living such as eating, bathing, dressing, personal hygiene and activities of daily living. Services may include assistance with preparation of meals, but not the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed-making, dusting and vacuuming, which are essential to the health and welfare of the recipient. Personal care is not available to residents of a group home or other residential setting.

(b) Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of the personal care service. In order for this component to be reimbursed, the personal care attendant must support the consumer's need to access the community and not merely to provide transportation. The Personal Care Transportation service will provide transportation in the community to shop, attend recreational and civic events, go to work, and participate in *People First* and other community building activities. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported.

(c) The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer.

(d) Personal Care Transportation shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost effective means of transportation which would include public transportation where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

(e) Personal care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. This service must be billed under a separate code to distinguish it from other personal care activities.

(13) Environmental Accessibility Adaptations

(a) Environmental accessibility adaptations are those physical adaptations to the home, required by the recipients' plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization.

1. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add square footage to the home are also excluded from this Medicaid reimbursed benefit. All services shall be provided in accordance with applicable State or local building codes.

(14) Medical Supplies

(a) Medical supplies are necessary to maintain the recipient’s health, safety, and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc.

(b) These medical supplies will only be provided when authorized by the recipient’s physician and shall meet applicable standards of manufacturer, design and installation. Providers of this service will be those who have a signed provider agreement with Medicaid and the Department of Mental Health and Mental Retardation. Medical supplies are limited to a maximum of $1,800.00 per recipient per year. The operating agency (OA) must maintain documentation of items purchased for the recipient.

(15) Skilled Nursing

(a) Skilled nursing services are services listed in the plan of care which are within the scope of the Alabama Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Service consists of nursing procedures that meet the person’s health needs as ordered by a physician. Services will be billed by the hour. There is no restriction on the place of service.

(16) Specialized Medical Equipment

(a) Specialized medical equipment includes devices, controls, or appliances specified in the plan of care, which enable recipients to increase their ability to perform activities of daily living or to perceive, control or communicate with the environment in which they live. Included items are those necessary for life support, and equipment necessary for the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items that are not of direct medical or remedial benefits to the recipient. Invoices for medical equipment must be maintained in the case record. This service must be necessary to prevent institutionalization of the recipient. All items shall meet applicable standards of manufacturer, design and installation. Costs are limited to $5,000 per recipient, per year.

(17) Community Specialist Services

(a) Community Specialist Services include professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that these functions will incorporate person-centered planning, whereas case management does not.

(b) The provider must meet QMRP qualifications and be free of any conflict of interest with other providers serving the consumer. A community specialist with expertise in person centered planning may also be selected by the consumer to facilitate the interdisciplinary planning term meeting.

(c) Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

(d) The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver.

(e) The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions, will not overlap with case management. If the consumer or family chooses to have the community specialist remain involved for a longer period of time, the targeted case manager will visit the consumer every 180 days and call at 90-day intervals to ensure services are being delivered and satisfactory.

(f) The community specialist will communicate with the case manager quarterly to remain abreast of the client's needs and condition.

(g) A community specialist who facilitates the planning meeting for a person shall not have any conflict of interest with any provider who may wish to serve the person.

(h) This service is a cost-effective and necessary alternative to placement in an ICF-MR. A unit of service is 15 minutes.

(18) Crisis Intervention

(a) Crisis intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

(b) Crisis intervention may be provided in any setting in which the consumer resides or participates in a program. The service includes consultation with family members, providers, and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

(c) Crisis intervention will respond intensively to resolve crisis situations and prevent the dislocation of the person at risk such as individuals with mental retardation who are occasionally at risk of being moved from their residences to institutional settings because of family's inability to cope with short term, intense crisis situations. This service is a cost-effective alternative to placement in an ICF-MR.

(d) Crisis intervention services are expected to be of brief duration (8 weeks, maximum). When services of a greater duration are required, the individual shall be transitioned to a more appropriate service program or setting.

(e) Crisis intervention services require two levels of staff, professional and technician.

(f) A unit of service is 15 minutes and must be provided by the waiver planning team, directed by a graduate psychologist or licensed social worker.

(g) When the need for this service arises, the service will be added to the plan of care for the person.

(h) A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided.

(i) All crisis intervention services shall be approved by the regional community service office of the DMH/MR prior to the service being initiated.

(j) Crisis intervention services will not count against the $25,000 per recipient per year cap in the waiver, since the need for the service cannot accurately be predicted and planned for ahead of time.

(k) Specific crisis intervention service components may include the following:

1. Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;
2. Assessing which components are the most effective targets of intervention for the short-term amelioration of the crisis;
3. Developing and writing an intervention plan;
4. Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following up to ensure positive outcomes from interventions or to make adjustments to interventions;
5. Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;
6. Assisting the consumer with self care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situations; and
7. Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary caregiver, death of loved one, etc.

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.

History: Rule effective July 9, 1985. **Amended:** November 18, 1987 and January 14, 1997. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed November 19, 2007; effective February 15, 2008. **Amended:** Filed January 21, 2009; effective April 17, 2009.

Rule No. 560-X-35-.03. Eligibility.

Eligibility criteria for home and community-based services recipients shall be the same as eligibility criteria for an ICF/MR. Thus services will be available to Persons with Mental Retardation who would be eligible for institutional services under 42 CFR 435.217 and who are now eligible under 435.120. Mentally Retarded persons who meet categorical (including 42 CFR 435.120) medical and/or social requirements for Title XIX coverage will be eligible for home- and community-based services under the waiver. Applicants found eligible shall not be required to apply income above the personal needs allowance reserved to institutional recipients toward payment of care.

(1) Financial eligibility is limited to those individuals receiving SSI, Medicaid for Low Income Families (MLIF), SSI related protected groups deemed to be eligible for SSI/Medicaid (Widow/Widower, Disabled Adult Child, Continuous (Pickle) Medicaid), Federal and State adoption subsidy individuals, and special home and community-based optional categorically needy group whose income is not greater than 300 percent of the SSI federal benefit rate.

(2) Medical eligibility is limited to those individuals that meet the ICF/MR facility level of care. No waiver services will be provided to a recipient residing in an institutional facility, or has a primary diagnosis of mental illness, or whose health and safety is at risk in the community.

(3) Financial determinations and redeterminations shall be made by the Alabama Medicaid Agency, the Department of Human Resources or the Social Security Administration, as appropriate. In addition to the financial and medical eligibility criteria, the Alabama Medicaid Agency is limited to the number of recipients who can be served by the waiver.

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended**: November 18, 1987. Effective date of this Amendment January 14, 1997. **Amended**: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed October 21, 2004; effective January 14, 2005. **Amended:** March 21, 2005; effective June 16, 2005. **Amended:** Filed January 20, 2010; effective April 16, 2010.

Rule No. 560-X-35-.04. Characteristics of Persons Requiring ICF/MR Care:

(1) Generally, persons eligible for the level of care provided in an ICF/MR are those persons who need such level of care because the severe, chronic nature of their mental impairment results in substantial functional limitations in three or more of the following areas of life activity:

Self Care
Receptive and expressive language
Learning
Self-direction
Capacity for independent living
Mobility

(2) Services provided in an intermediate care facility for the mentally retarded in Alabama are those services that provide a setting appropriate for a functionally mentally retarded person in the least restrictive productive environment currently available. Determination regarding eligibility for ICF/MR care is made by a Qualified Mental Retardation Professional (QMRP). A QMRP is an individual possessing, at minimum, those qualifications in 42 C.F.R. Section 483.430. Recommended continued stay is made by an interdisciplinary team of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, and certified by a QMRP and a physician.

(3) ICF/MR care includes those services that address the functional deficiencies of the beneficiaries and that require the skills of a QMRP to either provide directly or supervise others in the provision of services needed for the beneficiary to experience personal hygiene, participate in daily living activities appropriate to his functioning level, take medication under appropriate supervision (if needed), receive therapy, receive training toward more independent functioning, and experience stabilization as a result of being in the least restrictive, productive environment in which he or she can continue his/her individual developmental process.

Author: Laura Walcott, Administrator, LTC Program Management Unit.
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended:** November 18, 1987. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-35-.05. Qualifications of Staff Who Will Serve As Review Team for Medical Assistance.

(1) The nurse shall be a graduate of a licensed school of nursing with a current state certification as a Licensed Practical Nurse (LPN) or Registered Nurse (RN). This person shall have knowledge and training in the area of mental retardation or related disabilities with a minimum of two (2) years' experience.

(2) The social worker shall be a graduate of a four-year college with an emphasis in social work. This person shall have knowledge and training in the area of mental retardation or related disabilities with a minimum of two (2) years' experience.

(3) The psychologist shall be a PH.D. in Psychology. This person shall be a licensed psychologist with general knowledge of test instruments used with the mentally retarded or related disabilities with a minimum of two (2) years' experience.

(4) Other professional disciplines which may be represented on the assessment team as necessary depending on the age, functional level, and physical disability of the clients are as follows:

(a) Special Education
(b) Speech Pathologist
(c) Audiologist
(d) Physical Therapist
(e) Optometrist
(f) Occupational Therapist
(g) Vocational Therapist
(h) Recreational Specialist
(i) Pharmacist
(j) Doctor of Medicine
(k) Psychiatrist
(l) Other skilled health professionals

Authority: 42 C.F.R. Section 441, Subpart G, and the Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled. Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.06. Financial Accountability.

(1) The financial accountability of providers for funds expended on Home and Community-Based services must be maintained and provide a clearly defined audit trail. Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients through the renewal period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the State of Alabama, the provider will pay the travel cost of the auditors to the location of the records.

(2) The MR Waiver has transitioned from a cost-based reimbursement system to a fee-for-service payment system. In order to ensure that the payments in a fee-for-service system are proper, the providers will be required to maintain cost report data and to submit Medicaid cost reports for three cost report periods. The cost report periods are: October 1, 2004 through December 31, 2004; January 1, 2005 through September 30, 2005; October 1, 2005 through September 30, 2006. Cost reports are due to Medicaid no later than ninety (90) days after the ending date of the reports as indicated above. Extension may be granted only upon written request. If a complete cost report is not filed by the due date or an extension is not granted, a penalty of $100 per day for each day past the due date will be imposed on the provider. The penalty will not be a reimbursable Medicaid cost. For detailed information on penalties see MR Waiver Fiscal Procedures Manual.

(3) Auditing Standards - Office of Management and Budget (OMB) Circular A-87, “Cost Principles for state and local government" will apply to governmental agencies participating in this program. For non-governmental agencies, OMB Circular, A-110 (Uniform administrative requirements for grants and other agreements with Institutions of Higher Education, hospitals and other non-profit organizations) and generally accepted accounting principles will apply. Governmental and non-governmental agencies will utilize the accrual method of accounting unless otherwise authorized by the Alabama Medicaid Agency.

(4) Cost Allowable and Unallowable

(a) 45 C.F.R., part 95, specifies dollar limits and accounting principles for the purchase of equipment. Purchases above the twenty-five thousand dollar limit require the approval of Medicaid.

(b) OMB Circular A-87 establishes cost principles for governmental agencies. For governmental agencies, all reported costs will be adjusted to actual costs at the end of the fiscal year.

(c) Contract payments for the delivery of specific services are allowable expenses. Thus, contracts for residential habilitation training, day habilitation training, prevocational services, supported employment, occupational therapy, speech therapy, physical therapy, individual family support services, behavior management, companion services, respite care, personal care, environmental modifications, specialized medical equipment and supplies, assistive technology, personal emergency response system, and skilled nursing are recognized expenses.

(d) Allowable costs are defined in OMB Circular A-122 (cost principles for non-profit organization) or OMB Circular A-87. Detailed descriptions of allowable costs and restrictions on those costs are found in the MR Waiver Fiscal Procedures Manual.

(e) Unallowable costs are specified in OMB Circular A-87 or Circular A-122. In addition to these, the following are not covered by this program:

1. Costs covered by other programs, such as:
   - (i) Prescription drug
   - (ii) Dental expenses
   - (iii) Ambulance
   - (iv) Physician's fees
   - (v) Lab expenses for clients
   - (vi) Oxygen

(vii) Inhalation therapy
(viii) Group therapy

2. The cost of advisory council consultants without Alabama Medicaid Agency's approval.

3. Legal fees as follows:
(i) Retainers
(ii) Relating to fair hearings
(iii) In connection with law suits that result in an adverse decision for the provider
(iv) Services that duplicate functions performed by Medicaid or the providers, such as eligibility determination for the program,
(v) Other legal fees not relating to the provision of services to the beneficiaries

4. Dues and subscriptions not related to services authorized under the waiver.

5. Detailed description of unallowable costs is specified in the MR Waiver Policy and Procedures Manual.

(5) Cost Allocation Plans

(a) State agencies are required to have a cost allocation plan approved by the Division of Cost Allocation (DCA) when the agencies handle multiple federal funds. The format of a cost allocation plan is specified by 45 C.F.R. 95.507, which also calls for written agreements between state agencies. Existence of such a plan will be an item of audit.

(b) Direct costs are charged to the specific services that incurred them. It is the indirect/overhead costs that are allocated to the specific fund. If there is more than one project with a fund, there must be a written plan to distribute costs among the projects. Within this project, there are two types of indirect costs. The first are those that can be associated with the services that are provided, such as an assessment at the central office that verifies the quality of service. This cost can be prorated to each service by a method described in writing. This first type of cost qualifies for the federal match benefit percentage. The second type of cost is reimbursed at the administrative federal financial participation rate. See rule 560-X-35.09 (8) for definition.

(c) Contracts which are used for procuring services from other governmental agencies must be cost-allocated. At a minimum, these contracts should meet the requirements of 45 C.F.R. 95.507; these contracts must indicate:

1. The specific services being purchased

2. The basis upon which the billing will be made (e.g., time reports, number of homes inspected, etc.).

Author: Samantha McLeod, Administrator, LTC Program Management Unit.
Statutory Authority: 42 CFR, Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended**: November 18, 1987, November 10, 1988, and May 15, 1990. Effective date of this Amendment January 14, 1997. **Amended:** Filed October 21, 2004; effective January 14, 2005. **Amended:** Filed January 21, 2009; effective April 17, 2009.

Rule No. 560-X-35-.07. Individual Assessments.

(1) Alabama Medicaid Agency will require an individual plan of care for each waivered service recipient. Such plan, entitled "Individual Habilitation Plan" (IHP), is subject to review by the Alabama Medicaid Agency and Department of Health and Human Services. Client assessment procedures in place in the Alabama Department of Mental Health and Mental Retardation, which are based on eligibility criteria for ICF/MRs developed jointly by DMH/MR and the Alabama Medicaid Agency, will be utilized by the Department of Mental Health and Mental Retardation (or its contract service providers) in screening for eligibility for the waivered services as an alternative to institutionalization. Whether performed by a qualified practitioner in the Department of Mental Health and Mental Retardation, its contract service providers, or provided by qualified (Diagnostic and Evaluation Team) personnel of the individual/agency arranging the service, review for "medical assistance" eligibility determination will be based on client assessment data, and the criteria for admission to an ICF/MR, as described in Rule No. 560-X-35-.03. Re-evaluation of clients shall be performed on an annual basis. Written documentation of all assessments will be maintained in the client's case file and subject to review by the Alabama Medicaid Agency and Department of Health and Human Services.

(2) The Alabama Medicaid Agency will give notice of services available under the waiver as required by federal regulations, particularly to primary care givers for the target group, including but not limited to, programs operated by Alabama Department of Mental Health and Mental Retardation, the statewide network of community MH/MR centers, and to other appropriate care-giving agencies such as county Department of Human Resources offices, hospitals, hospital associations, and associations for the mentally retarded.

Authority: 42 C.F.R. Section 441, Subpart G and the Home-and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled. Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.08. Informing Beneficiaries of Choice.

(1) Alabama Medicaid Agency will be responsible for assurances that beneficiaries of the waiver service program will be advised of the feasible service alternatives and be given a choice of which type of service--institutional or home- and/or community-based services--they wish to receive.

(2) Residents of long-term care facilities for whom home- and community-based services become a feasible alternative under this waiver will be advised of the available alternative at the time of review. Applicants for SNF, ICF, ICF/MR services, or a designated responsible party with authority to act on the applicant's behalf, will be advised of feasible alternatives to institutionalization at the time of their entry into a treatment system wherein an alternative is professionally determined to be feasible. All applicants found eligible for will be offered the alternative unless there is reasonable expectation that services required for the applicant would cost more than institutional care. Provisions for fair hearings for all persons eligible for services under this waiver will be made known and accessible to potential eligibles in accordance with Fair Hearings Procedures in place in the Alabama Medicaid Program.

Authority: 42 C.F.R. Section 441, Subpart G and the Home- and Community-Based Waiver for the Mentally Retarded and Developmentally Disabled. Rule effective July 9, 1985. Amended November 18, 1987. Effective date of this amendment May 15, 1990.

Rule No. 560-X-35-.09. Payment Methodology for Covered Services.

(1) The Medicaid reimbursement for each service provided by a mental health service provider shall be based on a fee-for-service system. Each year's rate will be trended forward by using the prior year's rate adjusted by the medical portion of the consumer price index. The new rate will be reported to the Alabama Medicaid Agency fiscal agent liaison to be input into the system.

(2) Providers should bill no more than one month's services on a claim for a recipient. There may be multiple claims in a month, but no single claim may cover services performed in different months. For example, October 15, 1990, to November 15, 1990, would not be allowed. If the submitted claim covers dates of service, part or all of which were covered in a previously paid claim, it will be rejected. Payment will be based on the number of units of service reported for HCPCS codes.

(3) The basis for the fees will be the past rate history and amount of care needed based on acuity of client disability with consideration being given to the medical care portion of the consumer price index.

(4) All claims for services must be submitted within six months from the date of service.

(5) Accounting for actual cost and units of services provided during a waiver year must be accomplished on HCFA's form 372.

Author: Laura Walcott, Administrator, LTC Program Management Unit
Statutory Authority: 42 C.F.R. Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective July 9, 1985. **Amended**: November 18, 1987, May 15, 1990, and January 14, 1997. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Filed October 21, 2004; effective January 14, 2005.

Rule No. 560-X-35-.10. Third Party Liability.

Providers shall make all reasonable efforts to determine if there is a liable third party source, including Medicare, and in the case of a liable third party source, utilize that source for payments and benefits prior to applying for Medicaid payments. Third party payments received after billing Medicaid for service for a Medicaid recipient shall be refunded to the Alabama Medicaid Agency.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR, Section 433, Subpart D – Third Party Liability.
History: Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.11. Payment Acceptance.

(1) Payment made by the Medicaid Program to a provider shall be considered to be payment in full for covered services rendered.

(2) No Medicaid recipient shall be billed for covered Medicaid services for which Medicaid has been billed.

(3) No person or entity, except a liable third party source, shall be billed for covered Medicaid services.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR Section 447, Subpart A – Payments: General Provisions. **History:** Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.12. Confidentiality.

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon the written consent of the recipient, his/her attorney, or his/her guardian, or upon subpoena from a court of appropriate jurisdiction.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR Section 431.306, Subpart F – Safeguarding Information on Applicants and Recipients.
History: Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.13. Records.

(1) The Department of Mental Health and Mental Retardation shall make available to the Alabama Medicaid Agency at no charge, all information regarding claims submitted and paid for services provided eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. Complete and accurate medical/psychiatric and fiscal records which fully disclose the extent services shall be maintained by the clinic. Said records shall be retained for the period of time required by state and federal laws.

(2) Sign-in log, service receipt, or some other written record shall be used to show the date and nature of services; this record shall include the Recipient's signature.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR Section 431.107, Subpart C – Administrative Requirements: Provider Relations.
History: Rule effective July 9, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-35-.14. Service Providers.

The Home and Community-Based MR Waiver is a cooperative effort between the Alabama Medicaid Agency and the Department of Mental Health and Mental Retardation.

Author: Laura Walcott, Administrator, LTC Program Management Unit.
Statutory Authority: The Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective January 14, 1997. **Amended:** Filed October 21, 2004; effective January 14, 2005.

Rule No. 560-X-35-.15. Application Process.

(1) The Alabama Medicaid Agency will provide the operating agency with the approved level of care determination process.

(2) The operating agency will review the applicant’s eligibility status to determine if the applicant is medically and financially eligible for waiver services. The targeted case manager will assist the recipient to make financial application and ensure that the appropriate documents are completed and routed to the appropriate Medicaid District Office.

(3) All recipients who are applying for an HCBS waiver who are financially approved by the Department of Human Resources or are under the age of 65 and have not been determined disabled must have a disability determination made by the Medical Review team of the Alabama Medicaid Agency.

(4) If a disability determination has been made, the Regional Office should complete a slot confirmation form (Form 376).

(5) The Qualified Mental Retardation Professional (QMRP) will complete the level of care determination and the plan of care development.

(6) The operating agency will be required to adhere to all federal and state guidelines in the determination of the level of care approval.

(7) During the assessment, it must be determined that "without waiver services the client is at risk of institutionalization."

(8) The operating agency or its designee (case manager), will ensure that the applicant has been screened and assessed to determine if the services provided through the MR Waiver will meet the applicant's needs in the community.

(9) The Alabama Department of Mental Health and Mental Retardation (ADMH/MR) is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community-based services in accordance with the provisions of the Home and Community-Based Waiver for Persons with Mental Retardation.

(10) The Alabama Medicaid Agency will provide to the ADMH/MR the approved Level of Care criteria and policies and procedures governing the level of care determination process.

(11) The ADMH/MR will designate a qualified medical professional to approve the level of care and develop the Plan of Care.

(12) ADMH/MR may utilize Medicaid staff for consultation on questionable admissions and annual redeterminations prior to a final decision being rendered.

(13) The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a random sample of individuals served under the Home and Community Based Waiver for Persons with Mental Retardation to determine appropriate admissions and annual redeterminations. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met. The Waiver Quality Assurance Unit conducts a random sample of plans of care and related documents annually.

(14) The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal, medical necessity, and eligibility requirements are not met.

(15) The Alabama Medicaid Agency may seek recoupment from ADMH/MR for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have

been eligible for the Home and Community-Based Waiver for Persons with Mental Retardation or Medicaid eligibility but for the certification of waiver eligibility by ADMH/MR.

(16) The operating agency or its designee will develop a plan of care that includes waiver as well as non-waiver services.

(17) Upon receipt of the financial award letter from the Alabama Medicaid Agency, the LTC Admissions Notification Form should be completed and forwarded to EDS electronically. EDS will either accept or reject the transmission of the LTC Admissions Notification Form. The operating agency or its designee will receive notice of the status of applications transmitted the next business day following the transmission.

(18) If EDS accepts the transmission, the information is automatically written to the Long Term Care file. The operating agency or its designee can begin rendering services and billing the Alabama Medicaid Agency for services rendered.

(19) If EDS rejects the transmission, the operating agency or its designee must determine the reason for the rejection and retransmit the LTC Admissions Notification Form.

(20) Neither the Alabama Medicaid Agency nor EDS will send out the LTC-2 Notification letters. The record of successful transmission will be your record of "approval" to begin rendering service.

(21) For applications where the level of care is questionable, you may submit the applications to the LTC Medical and Quality Review Unit for review by a nurse and/or a Medicaid physician.

(22) Once the individual's information has been added to the Long Term Care File, changes can only be made by authorized Medicaid staff.

Author: Samantha McLeod, Administrator, LTC Program Management Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Waiver for Persons with Mental Retardation.
History: Rule effective January 14, 1997. **Amended**: Filed May 20, 2003; effective August 18, 2003. **Amended:** Filed October 21, 2004; effective January 14, 2005. **Amended:** Filed November 19, 2007; effective February 15, 2008.

Rule No. 560-X-35-.16. Cost for Services.

(1) The cost for services to individuals who qualify for Home and Community-Based care under the waiver program will not exceed on an average per capita basis the total expenditures that would be incurred for such individuals if Home and Community-Based services were not available.

Authority: 42 C.F.R. Section 441, Subpart G and the MR/DD Waiver. Rule effective January 14, 1997.

Rule No. 560-X-35-.17. Fair Hearings.

(1) An individual who is denied Home and Community-Based Services based on Rule No. 560-X-35-.03, may request a fair hearing in accordance with 42. C.F.R. 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code.

(2) Recipients will be notified in writing at least ten days prior to termination of service.

(3) A written request for a hearing must be filed within sixty days following notice of action with which an individual is dissatisfied.

Authority: 42 C.F.R. Section 431, Subpart E. Rule effective January 14, 1997.

Rule No. 560-X-35-.18. Reserved.

Chapter 36. Home-and Community-Based Services for the Elderly and Disabled.

Rule No. 560-X-36-.01. Authority and Purpose.

(1) Home- and community-based services to the elderly and disabled are provided by the Alabama Medicaid Agency to categorically needy individuals who would otherwise require institutionalization in a nursing facility. These services are provided through a Medicaid waiver under the provisions of Section 1915(c) of the Social Security Act for an initial period of three years and for five-year periods thereafter upon renewal of waiver by the Centers for Medicare and Medicaid Services (CMS). Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan.

(2) The purpose of providing home- and community-based services to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care. Waiver services are not entitlements but are based on individual client needs. The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers enrolled for each service included in his or her written plan of care.

(3) Waiver services provided to eligible Medicaid recipients must be identified on the individual's Plan of Care and the Service Authorization Form. Waiver services provided but not listed on the Plan of Care and the Services Authorization Form are not reimbursable. Payments rendered for services not present on the Plan of Care and the Service Authorization Form will be recovered.

(4) It is not the intent of the E/D Waiver Services program to provide 24 hour in home care. Should 24 hour in home care become necessary in order to protect the health and safety of the waiver client, the appropriateness of waiver services should be assessed and other alternatives considered.

Author: Patricia Harris, Administrator, LTC Program Management Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 C.F.R. Section 441, Subpart G.
History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, and May 15, 1990. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-36-.02. Eligibility.

(1) Financial eligibility is limited to those individuals receiving SSI, individuals deemed to be receiving SSI, the optional categorically needy at a special income level of 300 percent of the Federal Benefit Rate (FBR) who are receiving HCBS waiver services, individuals receiving State Supplementation, and individuals receiving State or Federal Adoption Subsidies.

(2) Medical eligibility is determined based on current admission criteria for nursing facility care as described in Rule No. 560-X-10-.10.

(3) No waiver services will be provided to recipients in a hospital or nursing facility. Discharge planning by a case manager is a reimbursable service.

(4) The Alabama Medicaid Agency or its operating agencies acting on Medicaid's behalf may also deny home- and community-based services if it is determined that an individual's health and safety is at risk in the community; if the cost of serving an individual on the waiver exceeds the cost of caring for that individual in a nursing facility; if the individual does not cooperate with a provider in the provision of services; or if an individual does not meet the goals and objectives of being on the waiver program.

(5) The Alabama Medicaid Agency is restricted by the waiver to serving the estimated annual unduplicated number of beneficiaries approved by CMS.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled.
History: Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed July 20, 2005; effective October 14, 2005. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-36-.03. Operating Agencies.

The Home- and Community-Based Waiver for the Elderly and Disabled is a cooperative effort among the Alabama Medicaid Agency, and the state agencies as specified in the approved waiver document. The State affirms that it will abide by all terms and conditions set forth in the waiver.

Author: Patricia Harris, Administrator, LTC Program Management Unit
Statutory Authority: The Home- and Community-Based Waiver for the Elderly and Disabled.
History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-36-.04. Covered Services.

(1) Case Management Services.

(a) Case management is a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization. A case manager is responsible for outreach, intake and referral, diagnosis and evaluation, assessment, care plan development, and implementing and tracking services to an individual. All E/D waiver recipients will receive case management services.

(b) Case Management must be on the Plan of Care as a waiver service. Waiver services not listed on the Plan of Care and the Service Authorization Form will not be paid. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(c) Case management will be provided by a case manager employed by or under contract with the state agencies as specified in the approved waiver document. The case manager must meet the qualifications as specified in the approved waiver document.

(2) Homemaker Services.

(a) Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning, and personal services. They are provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself.

(b) A person providing homemaker services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(3) Personal Care Services.

(a) Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, supervision of the self-administering of medications, and securing health care from appropriate sources.

(b) A person providing personal care services must be employed by a certified Home Health Agency or other agency approved by the Alabama Medicaid Agency and supervised by a registered nurse, and meet the qualifications of a Personal Care Attendant as specified in the approved waiver document. This person may not be a relative, as defined by CMS, of the recipient.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services furnished by a member of the recipient's family.

(e) No payment will be made for services not listed on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(4) Adult Day Health Services.

(a) Adult Day Health Service provides social and health care in a community facility approved to provide such care. Health education, self-care training, therapeutic activities, and health screening shall be included in the program.

(b) Adult Day Health is purchased from facilities that meet the minimum standards for Adult Day Health Centers as described in Appendix C of the Home and Community-Based Waiver for the Elderly and Disabled. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health meets the prescribed standards.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services not listed on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(5) Respite Care.

(a) Respite care is given to individuals unable to care for themselves on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite care is provided in the individual's home and includes supervision, companionship and personal care of the individual. Respite is intended to supplement not replace care provided to waiver clients. Respite is not an entitlement. It is based on the needs of the individual client and the care provided by the primary caregiver.

(b) Respite care may be provided by a companion/sitter, personal care attendant, home health aide, homemaker, LPN or RN, depending upon the care needs of the individual. All other waiver services will be discontinued during the in-home respite period.

(c) Payment will not be made for respite care furnished by a member of the recipient's family; may not exceed 720 hours or 30 days per waiver year (October 1 through September 30); must not be used to provide continuous care while the primary caregiver is employed or attending school.

(d) Medicaid will not reimburse for activities performed which are not within the scope of services.

(e) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(6) Adult Companion services:

(a) Adult companion services are non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

(b) Other service definitions include accompanying a client to a medical appointment, grocery shopping or picking up prescription medications. The companion service is available to only those clients living alone. Companion services cannot be provided on the same dates of services as other approved waiver services with the exception of case management services. Companion services must not exceed four (4) hours daily. Payment will not be made for companion services furnished by a member of the recipient's family.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) Companion service is not an entitlement. It is based on the needs of the individual client.

(e) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the Plan of Care shall be recovered.

(7) Home Delivered Meals

(a) Home delivered meals are provided to an eligible individual age 21 or older who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home-delivered meals.

(b) This service will provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability/dependency and who require nutritional assistance to remain in the community, and do not have a caregiver available to prepare a meal for them.

(c) This service will be provided as specified in the care plan and may include seven (7) or fourteen (14) frozen meals per week. Recipients will be authorized to receive one (1) unit of service per week. One unit of service is a 7-pack of frozen meals. Clients authorized to receive two (2) units of service per week will receive two 7-packs of frozen meals or one 7-pack of frozen meals and one 7-pack of breakfast meals.

(d) In addition to the frozen meals, the service may include the provision of two (2) or more shelf-stable meals (not to exceed six (6) meals per six-month period) to meet emergency nutritional needs when authorized in the recipient's care plan.

(e) One frozen meal will be provided on days a recipient attends the Adult Day Health Centers. Meals provided, as part of this service, shall not constitute a "full nutritional regimen (three meals per day)".

(f) All menus must be reviewed and approved by the Meals Services Coordinator, a Registered Dietitian with licensure to practice in the State of Alabama and employed by the Operating Agency.

(g) The meals must be prepared and/or packaged, handling, transported, served, and delivered according all applicable health, fire, safety, and sanitation regulations.

(h) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not documented on the individual's Plan of Care will be recouped.

(i) During times of the year when the State is at an increased risk of disaster from hurricanes, tornadoes, or ice/snow conditions, the meals vendor will be required to maintain, at a minimum, a sufficient inventory to operate all frozen meals delivery routes for two days. In the event of an expected storm or disaster, the Meals Coordinator will authorize implementation of a Medicaid approved Disaster Meal Services Plan.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 440.180 and the Home and Community-Based Waiver for the Elderly and Disabled.
History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-36-.05. Costs for Services.

The costs for services to individuals who qualify for home- and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home- and community-based services were not available.

Authority: 42 C.F.R. Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled. Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Effective date of this amendment November 18, 1987.

Rule No. 560-X-36-.06. Application Process.

(1) The case manager will receive referrals from hospital, nursing homes, physicians, the community and others for persons who may be eligible for home- and community-based services.

(2) An assessment document will be completed by the case manager in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of the initial assessment must be completed annually with each annual redetermination of eligibility.

(3) The case manager, in conjunction with the applicant's physician will develop a plan of care. All services will be furnished pursuant to a written plan of care. Payment will not be made for waiver services furnished prior to the development of the plan of care. The plan of care will include objectives, services, provider of services, and frequency of services. Changes to the original plan of care are to be made as needed to adequately care for an individual. Revisions to the plan of care and the reasons for changes must be documented in the client's case record. Services provided must be documented on the client's care plan which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the case manager as often as necessary and administered in coordination with the recipient's physician.

(4) The Alabama Medicaid Agency has delegated the medical level of care determination to qualified trained individuals at the Operating agency.

(5) Medicaid requires the providers to submit an application in order to document dates of service provisions to long term care recipients.

(a) The long term care file maintains these dates of service.

(b) The applications will be automatically approved through systematic programming.

(c) The Quality Improvement and Standards Division will perform random audits on a percentage of records to ensure that documentation supports the medical level of care criteria, physician certification, as well as other state and federal requirements.

(6) The Alabama Department of Public Health (ADPH) and the Alabama Department of Senior Services (ADSS) are responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community-based services in accordance with the provisions of the Elderly and Disabled Waiver.

(7) The Alabama Medicaid Agency will provide to the ADPH and ADSS the approved Level of Care criteria and policies and procedures governing the level of care determination process.

(8) The ADPH and ADSS will designate a qualified medical professional to approve the level of care and develop the Plan of Care.

(9) Admissions, readmissions and annual redeterminations must be certified by a physician licensed to practice in Alabama.

(10) ADPH and ADSS may utilize Medicaid staff for consultation on questionable admissions and annual redeterminations prior to a final decision being rendered.

(11) The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a random sample of individuals served under the Elderly and Disabled Waiver to determine appropriate admissions and annual redeterminations. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

(12) The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal, medical necessity, and eligibility requirements are not met.

(13) The Alabama Medicaid Agency may seek recoupment from ADPH and ADSS for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for Elderly and Disabled Waiver services or Medicaid eligibility but for the certification of waiver eligibility by ADPH or ADSS.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled.
History: Emergency Rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed May 20, 2003; effective August 21, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-36-.07. Financial Accountability of Operating Agencies.

(1) The financial accountability of providers for funds expended on home- and community-based services must be maintained and provide a clearly defined audit trail. Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients for a five-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the state of Alabama, the provider will pay the travel cost of the auditors.

(2) The state agencies, as specified in the approved waiver document as operating agencies of home- and community-based services, will have their records audited at least annually at the discretion of the Alabama Medicaid Agency. Payments that exceed actual allowable cost will be recovered by Medicaid.

(3) The Alabama Medicaid Agency will review at least annually the recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

(4) The state agencies as specified in the approved waiver document will provide documentation of actual costs of services and ministration. Such documentation will be entitled "Quarterly Cost Report for the Elderly and Disabled Waiver" the "Quarterly Cost Report" will include all actual costs incurred by the operating agency for the previous quarter and include costs incurred year to date. This document will be submitted to the Alabama Medicaid Agency before the 1st day of the third month of the next quarter. Quarters are defined as follows:

(a) 1st October - December Due before March 1
(b) 2nd January - March Due before June 1
(c) 3rd April - June Due before September 1
(d) 4th June - September Due before December 1

Failure to submit the actual cost documentation can result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed.

(5) Auditing Standards - Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State and Local Governments" will apply to governmental agencies participating in this program. For non-governmental agencies, generally accepted accounting principles will apply. Governmental and non-governmental agencies will utilize the accrual method of accounting unless otherwise authorized by the Alabama Medicaid Agency.

(6) Cost, Allowable and Unallowable -

(a) 45 C.F.R., part 95, specifies dollar limits and accounting principles for the purchase of equipment. Purchases above the twenty-five thousand dollar limit require the approval of Medicaid.

(b) OMB Circular A-87 establishes cost principles for governmental agencies and will act as a guide for non-governmental agencies. For governmental agencies, all reported cost will be adjusted to actual cost at the end of the fiscal year.

(c) Contract payments for the delivery of the specific services are allowable expenses. Thus, contracts for case management, personal care, homemaker, respite care, adult day health, and home delivered meals are recognized expenses. All other contracts will require Medicaid approval to insure that functions are not being duplicated. For example, outreach is to be performed by the case manager, thus, it would not be appropriate to approve other contracts for outreach, unless it can be clearly shown that the function is required and cannot be provided within the established organization.

(d) Allowable costs are defined in OMB Circular A-87. However, the following restrictions apply:

1. Advertising is recognized only for recruitment of personnel, solicitation of bids for services or goods, and disposal of scrap or surplus. The cost must be reasonable and appropriate.

2. The cost of buildings and equipment is recognized. For governmental agencies, buildings and equipment exceeding twenty-five thousand dollars will be capitalized in accordance with 45 C.F.R. 95.705 and depreciated through a use allowance of two percent of acquisition cost for building and six and two-thirds percent for equipment. Equipment that has a remaining value at the completion of the project will be accounted for in accordance with 45 C.F.R. 95.707. For automated data processing equipment, see 45 C.F.R. 95.641. When approval is required, the request will be made to Medicaid agency in writing.

3. The acquisition of transportation equipment will require prior approval from the Alabama Medicaid Agency. When approval is required, the request will be made to Medicaid in writing.

4. Transportation is an allowable expense to be reimbursed as follows:

(i) For nongovernmental agencies, it will be considered as part of the contract rate.

(ii) For government and private automobiles utilized by state employees, reimbursement will be made at no more than the current approved state rate.

(iii) All other types of transportation cost will be supported by documents authorizing the travel and validating the payment.

(e) Unallowable costs are specified in OMB Circular A-87. In addition to these, the following are not covered by this program:

1. Cost covered by other programs, such as:

(i) Prescription drugs,
(ii) Dental expense,
(iii) Physical therapy,
(iv) Ambulance service,
(v) Inhalation, group, speech, occupational, and physical therapy.

2. The cost of advisory councils or consultants without Alabama Medicaid Agency's approval.

3. Legal fees as follows:

(i) Retainers,
(ii) Relating to fair hearing,
(iii) In connection with law suits, which result in an adverse decision,

(iv) Services that duplicate functions performed by Medicaid or the provider, such as eligibility determination for the program,

(v) Other legal fees not relating to the providing of services to the beneficiaries.

4. Dues and subscriptions not related to the specific services.

(7) Cost Allocation Plans

(a) State agencies are required to have a cost allocation plan approved by the Division of Cost Allocation (DCA) when the agencies handle multiple federal funds. The format of a cost allocation plan is specified by 45 C.F.R. 95.507, which also calls for written agreements, between state agencies. Existence of such a plan will be an item of audit.

(b) Direct costs are charged to the specific services that incurred them. It is the indirect/overhead costs that are allocated to the specific fund. If there is more than one project within a fund, there must be a written plan to distribute fund costs among the projects. Within this project, there are two types of indirect costs. The first are those that can be associated with the services that are provided, such as an assessment at the central office that verifies the quality of service. This cost can be prorated to each service by some method that is described in writing. This first type of cost qualifies for the federal match benefit percentage. The second type of allocated cost falls under the administration definition. For example, a mail distribution clerk that distributes to all programs. This second type has a federal match of 50/50; therefore, both types must be accounted for separately.

(c) Contracts which are used for procuring services from other governmental agencies must be cost-allocated. As a minimum, these contracts should meet requirements of 45 C.F.R. 95.507; these contracts must indicate:

1. "The specific services being purchased."
2. "The basis upon which the billing will be made - - (e.g., time reports, number of homes inspected, etc.)."
3. "A stipulation that the billing will be based on actual costs incurred." This is not a requirement for non-governmental agencies. For governmental agencies, the billing should be either actual cost or an agreed upon fixed fee approximating actual cost which will be adjusted to actual cost at completion of the fiscal year.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the Home- and Community-Based Waiver for the Elderly and Disabled.
History: Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987, May 15, 1990, and September 12, 1995. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-36-.08. Fair Hearings.

(1) An individual or his/her legal representative who has received a notice of adverse action based on financial eligibility may request a fair hearing in writing within 60 days from the effective date of the action through the appropriate certifying agency.

(2) An individual or his/her legal representative who has received a notice of adverse action based on medical criteria may request a fair hearing in writing within 60 days from the effective date of the action through the Alabama Medicaid Agency Long Term Care Division.

(3) If the written request for a fair hearing is received within 10 days following the effective date of the adverse action, benefits can be continued pending the outcome of the hearing, if requested in writing.

Author: Ginger Wettingfeld, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 431, Subpart E.

History: Emergency rule effective March 18, 1985. Rule effective July 13, 1985. Amended November 18, 1987 and May 15, 1990. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-36-.09. Payment Methodology for Covered Services.

(1) Medicaid pays providers the actual cost to provide the service. Each covered service is identified on a claim by a HCPC code. Respite care will have one code for skilled and another for unskilled. Home delivered meals will also have one code and two modifiers. Frozen meals and shelf stable meals will be billed with a modifier. Breakfast meals will be billed without a modifier.

(2) For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month, but no single claims can cover services performed in different months. If the submitted claim covers days of service part or all of which were covered in a previously paid claim, it will be rejected. Payment will be based on the number of units of service reported for each HCPC code.

(3) The basis for the cost will usually be based on audited past performance with consideration being given to the health care index and renegotiated contracts. The interim cost may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

(4) The operating agencies, the state agencies as specified in the approved waiver document are governmental agencies; therefore, within one hundred and twenty days from the end of a waiver year, the interim cost for services must be adjusted to cost and the claims for the services provided during that year reprocessed to adjust payments to the actual cost incurred by each operating agency. Thus the cost for each service for each operating agency may differ. Since the actual cost incurred by each operating agency sets a ceiling on the amount it can receive, no claims with dates of service within that year will be processed after the adjustment is made.

(5) Accounting for actual cost and units of services provided during a waiver year must be accomplished on HCFA's Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim cost:

(a) A waiver year consists of the twelve months following the start of any waiver year.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public (governmental) provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the state agency.

(c) The services provided by operating agencies are reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.

(6) Provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the cost for service. The administrative portion will be divided in twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver year is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost.

Author: Patricia Harris, Administrator, LTC Program Management Unit
Statutory Authority: 42 C.F.R. Section 440.180 and the Home- and Community Based Waiver for the Elderly and Disabled, 45 CFR, Subpart 95, and OMB Circular A-87.
History: Emergency Rule effective December 4, 1987. Rule effective March 12, 1988. Amended May 15, 1990 and September 12, 1995. **Amended:** Filed May 20, 1999; effective August 18, 1999. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed April 21, 2003; effective

July 16, 2003. **Amended:** Filed August 20, 2004; effective November 16, 2004. **Amended:** Filed March 21, 2005; effective June 17, 2005.

Rule No. 560-X-36-.10. Confidentiality.

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon the written consent of the recipient, his or her attorney, and/or guardian, or upon subpoena from a court of appropriate jurisdiction.

Author: Patricia Harris, Administrator, LTC Program Management Unit
Statutory Authority: 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed April 21, 2003; effective July 16, 2003.

Chapter 37. Managed Care

Rule No. 560-X-37-.01. General.

(1) The Agency may, at its discretion, and in consultation with local communities, organize and develop area specific systems as part of an overall managed care system.

(a) Flexibility. Since community needs and resources differ from area to area, the Agency will maintain the flexibility to design plans which are consistent with local needs and resources.

(b) Waiver Programs. Plans may be either voluntary or mandatory pursuant to waiver(s) granted by the Centers for Medicare and Medicaid Services (CMS) or the Office of State Health Reform Demonstration. Some plans may start as voluntary and subsequently become mandatory. All required federal waivers must be obtained by Medicaid before any system or contract can become effective.

(c) State Plan Programs. Amendments to the state plan must be approved by CMS before any system or contract can become effective.

(d) Models. It is anticipated that managed care will be accomplished through a combination of primary care case management systems (PCCM), health maintenance organizations (HMO), managed care organizations (MCO) and prepaid Inpatient health plans.

(e) Purpose. The purposes of managed care are to:

(i) Ensure needed access to health care;

(ii) Provide health education;

(iii) Promote continuity of care;

(iv) Strengthen the patient/physician relationship;

and

(v) Achieve cost efficiencies.

(2) (a) Any managed care system established shall comply with the approved Alabama State Plan for Medical Assistance, Alabama Medicaid Administrative Code, the Alabama Medicaid Provider Manual and/or operational protocols, all other guidelines of Medicaid program areas, all state and federal laws and regulations, and any federally approved waivers in effect in the geographical areas of the State in which the system is operational and providing medical services to eligible Medicaid enrollees.

(b) The regulations of CMS at 42 CFR Parts 430, 432, 434, 438, 440, and 447, as promulgated in 67 Federal Register 40988 (June 14, 2002) and 68 Federal Register 3586 (January 24, 2003), and as may be subsequently amended, are adopted by reference. Copies of these regulations may be obtained from the US Government Printing Office, Washington, DC 20402 or at www.gpo.gov.su_docs/aces/aces140.html. Copies are also available from Medicaid at a cost of $7.00.

(3) Any managed care system or provider shall comply with all federal and state laws, rules and regulations relating to discrimination and equal employment opportunity, Titles VI and VII of the Civil Rights Act of 1964, as amended, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and Americans with Disabilities Act of 1990.

(4) The terminology and definitions in this chapter may be referenced in their entirety in 42 CFR 438.2. An abbreviated list follows:

(a) *Capitation payment* means a payment the state agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the state plan.

(b) *Capitated risk contract* means a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the services listed in Rule 560-X-37-.03 (2).

(c) *Federally qualified HMO* means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

(d) *Health care professional* means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(e) *Health insuring organization (HIO*) means a county operated entity, that in exchange for capitation payments, covers services for recipients through payments to, or arrangements with, providers under a comprehensive risk contract with the state.

(f) *Managed care organization (MCO*) means an entity that has, or is seeking to qualify for, a comprehensive risk contract as defined in 42 CFR, Part 438, and that is a federally qualified HMO that meets the requirements of 42 CFR, Part 489, Subpart I.

(g) *Nonrisk contract* means a contract under which the contractor is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR, Section 447.362.

(h) *Prepaid ambulatory health plan (PAHP*) means an entity that provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

(i) *Prepaid inpatient health plan (PIHP*) means an entity that provides medical services to enrollees under contract with the state agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use state plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

(j) *Primary care* means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

(k) *Primary care case management* means a system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.

(l) *Primary care case manager (PCCM*) means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services.

(m) *Primary medical provider (PMP*) means a family practitioner, general practitioner, internist, or pediatrician, an entity that provides or arranges for PMP coverage for services, consultation, or referrals 24 hours a day, seven days a week.

(n) *Risk contract* means a contract under which the contractor assumes risk for the cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

(5) The contract requirements in this chapter may be referenced in their entirety in 42 CFR 438.6. An abbreviated list follows:

(a) The CMS Regional Office must review and approve all MCO, PIHP, and PAHP contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirement in 438.806.

(b) Payments under risk contracts must be based on actuarially sound capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; and are appropriate for the populations to be covered, and the services to be furnished under the contract.

(c) All contracts in this chapter must comply with all applicable federal and state laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

(d) Physician incentive plans (PIP) do not apply to contracts in this chapter.

(e) All MCO and PIHP contracts must provide for compliance with the requirements of 422.128 for maintaining written policies and procedures for advance directives. The entity subject to this requirement must provide adult enrollees with written information on advance directives policies, and include a description of applicable state law.

(f) PCCM contracts must meet the following requirements:

(i) Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

(ii) Restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

(iii) Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

(iv) Prohibit discrimination in enrollment, disenrollment, and reenrollment, based on the recipient's health status or need for health care services.

(v) Provide that enrollees have the right to disenroll from their PCCM in accordance with 438.56 (c).

(6) The information requirements in this chapter may be referenced in their entirety in 42 CFR 438.10. An abbreviated list follows:

(a) *Enrollee* means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

(b) *Potential enrollee* means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.

(c) Each state enrollment broker must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

(d) The state must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(e) The state must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the state. *Prevalent* means a non-English language spoken by a significant number of potential enrollees and enrollees in the state.

(f) The state and each managed care entity must make available written information in the prevalent non-English languages.

(g) The state must notify enrollees and potential enrollees and require each managed care entity to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages.

(7) The provider discrimination prohibitions in this chapter may be found in their entirety in 42 CFR 438.12. An abbreviated list follows:

(a) A managed care entity may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his license or certification under applicable state law, solely on the basis of that license or certification. If a managed care entity declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(b) In all contracts with health care professionals, a managed care entity must comply with the requirements in 438.214.

(8) The enrollment requirements in this chapter may be found in their entirety in 42 CFR 438.50 through 438.66. An abbreviated list follows:

(a) A state plan that requires Medicaid recipients to enroll in managed care entities must comply with the provisions of this section, except when the state imposes the requirement as part of a demonstration project under section 1115 of the Act; or under a waiver granted under section 1915(b) of the Act.

(b) The state plan must specify the types of entities with which the state contracts; whether the payment method is fee for service or capitated; whether it contracts on a comprehensive risk basis; and the process the state uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the state plan has been implemented.

(c) The plan must provide assurances that the state meets applicable requirements of section 1903(m) of the Act for MCOs; section 1905(t) of the Act for PCCMs; and section 1932(a)(1)(A) of the Act for the state's option to limit freedom of choice by requirring recipients to receive their benefits through managed care entities.

(d) The state must provide assurances that, in implementing the state plan managed care option, it will not require the following groups to enroll in an MCO or PCCM:

(i) Medicare eligible recipients;

(ii) Indians who are members of federally recognized tribes, except when the MCO or PCCM is the Indian Health Service or an Indian health program operated under a contract, grant, etc., with the Indian Health Service;

(iii) Children under 19 years of age who are eligible for SSI under title XVI; eligible under section 1902(e)(3) of the Act; in foster care or out of home placement; receiving foster care or adoption assistance; or receiving services through a community based care system.

(e) The state must have an enrollment system under which recipients already enrolled in an MCO or PCCM are given priority to continue that enrollment if the MCO or PCCM does not have the capacity accept all those seeking enrollment under the program.

(f) For recipients who do not choose an MCO or PCCM during their enrollment period, the state must have a default enrollment process for assigning those recipients to contracting MCOs and PCCMs.

(g) The process must seek to preserve existing provider-recipient relationships and relationships with providers that have traditionally served Medicaid recipients.

(h) An *existing provider-recipient relationship* is one in which the provider was the main source of Medicaid services for the recipient during the previous year.

(i) A provider is considered to have *traditionally served* Medicaid recipients if it has experience in serving the Medicaid population.

(9) The recipient choice requirements in this chapter may be found in their entirety in 42 CFR 438.52. An abbreviated list follows:

(a) A state that requires Medicaid recipients to enroll in an MCO, PIHP, PAHP or PCCM system must give those recipients a choice of at least two entities.

(b) A state may limit a rural area recipient to a single managed care entity with the exceptions noted in 438.52(b).

(c) A state may limit recipients to a single HIO if the recipient has a choice of at least two primary care providers within the entity.

(d) A state's limitation on an enrollee's freedom to change between primary care providers may be no more restrictive than the limitations on disrollment noted in 438.56.

(10) The disenrollment requirements and limitations in this chapter may be found in their entirety in 42 CFR 438.56. An abbreviated list follows:

(a) The provisions of this section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) All contracts must specify the reasons for which the entity may request disenrollment of an enrollee.

(c) The entity may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

(d) All contracts must specify the methods by which the entity assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(e) All contracts must specify that a recipient may request disenrollment for cause at any time, or without cause at the following times:

(i) During the 90 days following the date of the recipient's initial enrollment with the entity or the date the state sends the recipient notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

(f) Recipients (or their representatives) must submit oral or written requests for disenrollment to the state agency or the managed care entity (if the state permits the entity to process such requests).

(g) The following are cause for disenrollment:

(i) The enrollee moves out of the entity's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

(h) The state agency must complete the determination on the recipient's (or the entity's) request so that the effective date of disenrollment is no later than the first day of the second month following the month in which the recipient (or the entity) files the request.

(11) The state must have in effect safeguards against conflict of interest on the part of employees and agents of the state who have responsibilities relating to the managed care contracts. Medicaid employees must comply with the state ethics laws including, but not limited to, Code of Alabama (1975), Sections 36-25-5, -7, -8, -11, -12, and -13.

(12) The state must ensure that no payment is made to a provider other than the managed care entity for services available under the contract between the state and the entity. Medicaid ensures compliance with 438.60 through the systematic plan code determination at the detail level of a claim.

(13) The state must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of a managed care entity whose contract is terminated and for any Medicaid enrollee who is disenrolled from an entity for any reason other than ineligibility for Medicaid.

(14) The state must have in effect procedures for monitoring the entity's operations, including at a minimum, operations related to the following:

(a) Recipient enrollment and disenrollment.

(b) Processing of grievances and appeals.

(c) Violations subject to intermediate sanctions.

(d) Violations of the conditions for FFP.

(e) All other conditions of the contract as appropriate.

(15) The enrollee rights in this chapter may be found in their entirety in 42 CFR 438.100. An abbreviated list follows:

(a) The state must ensure that each managed care entity has written policies regarding the enrollee rights specified in 438.100.

(b) Each entity shall comply with any applicable federal and state laws that pertain to enrollee rights and shall ensure that its staff and providers take those rights into account when furnishing services to enrollees.

(c) An enrollee of a managed care entity has the right to:

(i) Receive information in accordance with 438.10.

(ii) Be treated with respect and with due consideration for this or her dignity and privacy.

(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

(iv) Participate in decisions regarding his or her health care.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

(vi) Request and receive a copy of his or her medical records, and request that they be amended or corrected.

(d) An enrollee of a managed care entity has the right to be furnished health care services in accordance with 438.206 through 438.210.

(e) The state must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the managed care entity and its providers treat the enrollee.

(f) The state must ensure that each entity complies with any other applicable federal and state laws.

(16) The provider-enrollee communications in this chapter may be found in their entirety in 42 CFR 438.102. An abbreviated list follows:

(a) A managed care entity may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

(i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(ii) Any information the enrollee needs in order to decide among all relevant treatment options.

(iii) The risks, benefits, and consequences of treatment or nontreatment.

(iv) The enrollee's rights to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(17) The marketing activities described in this chapter may be found in their entirety in 42 CFR 438.104. An abbreviated list follows:

(a) *Cold-call marketing* means any unsolicited personal contact by the managed care entity for the purpose of marketing.

(b) *Marketing* means any communication from a managed care entity to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular entity's Medicaid product, or either to not enroll in, or to disenroll from, another entity's Medicaid product.

(c) Each contract with a managed care entity must provide that the entity does not distribute any marketing materials without first obtaining state approval.

(18) The rules concerning liability for payment may be found in their entirety in 42 CFR 438.106. An abbreviated list follows:

(a) Each managed care entity must provide that its Medicaid enrollees are not held liable for any of the following:

(i) The entity's debts in the event of insolvency.

(ii) Covered services provided to the enrollee for which the state does not pay the entity, or the state or the entity does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.

(iii) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the entity provided the services directly.

(19) All contracts must provide that any cost sharing imposed on Medicaid enrollees is in accordance with 447.50 through 447.60.

(20) The rules concerning emergency and poststabilization services may be found in their entirety in 42 CFR 438.114. An abbreviated list follows:

(a) *Emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(ii) Serious impairment to bodily functions.

(iii) Serious dysfunction of any bodily organ or part.

(b) *Emergency services* means covered inpatient and outpatient services that are as follows:

(i) Furnished by a provider that is qualified to furnish these services.

(ii) Needed to evaluate or stabilize an emergency medical condition.

(c) *Poststabilization care services* means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

(21) The solvency standards in this chapter may be found in their entirety in 42 CFR 438.116. An abbreviated list follows:

(a) Each MCO, PIHP, and PAHP that is not a federally qualified HMO must provide assurances to the state showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the managed care entity's debts if the entity becomes insolvent.

(b) Federally qualified HMOs are exempt from this requirement.

(22) The quality assessment and performance improvement standards in this chapter may be found in their entirety in 42 CFR, 438.200. An abbreviated list follows:

(a) The state must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

(b) The state must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it as final.

(c) The state must ensure that MCOs, PIHPs, and PAHPs comply with standards established by the state consistent with the regulations found in 42 CFR, Part 438.

(d) The state must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy periodically as needed.

(e) The state must submit to CMS a copy of the initial strategy and the revised strategy whenever significant changes are made, as well as regular reports on the effectiveness of the strategy.

(23) The elements of state quality strategies in this chapter may be found in their entirety in 42 CFR 438.204. An abbreviated list follows:

(a) The contracts with MCOs and PIHPs must contain procedures that:

(i) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.

(ii) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. The state must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.

(iii) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.

(iv) Arrange for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered.

(24) The rules concerning availability of services in this chapter may be found in their entirety in 42 CFR 438.206. An abbreviated list follows:

(a) The state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs and PAHPs.

(b) The state must ensure through its contracts that each entity, consistent with the entity's scope of contracted services, meets the following requirements:

(i) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.

(ii) Considers the anticipated Medicaid enrollment.

(iii) Considers the expected utilization of services, taking into account the characteristics and health care needs of specific Medicaid populations represented in the particular entity.

(iv) Considers the numbers and types of providers required to furnish the contracted Medicaid services.

(v) Considers the numbers of network providers who are not accepting new Medicaid patients.

(vi) Considers the geographic location of providers and enrollees.

(c) Each entity must do the following:

(i) Meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services.

(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service.

(iii) Make services included in the contract available 24 hours a day, seven days a week when medically necessary.

(iv) Establish mechanisms to ensure compliance by providers.

(v) Monitor providers regularly to determine compliance.

(vi) Take corrective action if there is a failure to comply.

(25) The assurances of adequate capacity and services in this chapter may be found in their entirety in 42 CFR 438.207 An abbreviated list follows:

(a) The state must ensure, through its contracts, that each entity gives assurances to the state and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care.

(b) Each entity must submit documentation to the state, in a format specified by the state, to demonstrate that it complies with the following requirements:

(i) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.

(ii) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

(c) Each entity must submit the documentation to the state at the time it enters into a contract with Medicaid and at any time there has been a significant change in the entity's operations that would affect capacity and services.

(26) The requirements for coordination and continuity of care in this chapter may be found in their entirety in 42 CFR 438.208. An abbreviated list follows:

(a) Each managed care entity must implement procedures to deliver primary care and to coordinate health care service for all the entity's enrollees. These procedures must meet state requirements and must do the following:

(i) Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

(ii) Coordinate the services the entity furnishes to the enrollee with the services the enrollee receives from any other entity.

(iii) Share with other entities serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.

(iv) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with state and federal requirements to the extent that they are applicable.

(27) The requirements for coverage and authorization of services in this chapter may be found in their entirety in 42 CFR 438.210. An abbreviated list follows:

(a) Each contract with a managed care entity must identify, define, and specify the amount, duration, and scope of each service that the entity is required to offer.

(b) The services identified in each entity's contract must be furnished in the same manner that recipients receive under fee-for-service Medicaid.

(c) Each contract must ensure that the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services were furnished.

(d) The entity may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of a diagnosis, type of illness, or condition of the beneficiary.

(28) The requirements for provider selection in this chapter may be found in their entirety in 42 CFR, 432.214. An abbreviated list follows:

(a) Medicaid must ensure through its contracts that each entity implements written policies and procedures for selection and retention of providers.

(b) Medicaid must establish a uniform credentialing and recredentialing policy that each entity must follow.

(c) Each entity must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the entity.

(d) The entity's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(e) The managed care entities may not employ or contract with providers excluded from participation in federal health care programs.

(f) Each entity must comply with any additional requirements established by Medicaid.

(29) The enrollee information requirements that the state must meet under the regulations in 438.10 constitute part of Medicaid's quality strategy at 438.204.

(30) Medicaid must ensure, through its contracts, for medical records and any other health and enrollment information that identifies any particular enrollee, each entity uses and discloses such information in accordance with applicable state and federal laws.

(31) Medicaid must ensure that each entity's contract complies with the enrollment and disenrollment requirements and limitations set forth in 438.56.

(32) Medicaid must ensure, through its contracts, that each entity has in effect a grievance system that meets the requirements of 438.400 through 438.424.

(33) The requirements concerning subcontractual relationships and delegation in this chapter may be found in their entirety in 42 CFR 438.230. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

(b) Before any delegation, each entity must evaluate the prospective subcontractor's ability to perform the activities to be delegated.

(c) A written agreement between the entity and the subcontractor must specify the activities and report responsibilities delegated to the subcontractor; and must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(34) The requirements for practice guidelines in this chapter may be found in their entirety in 42 CFR 438.236. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity adopts practice guidelines that meet the following requirements:

(i) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

(ii) Consider the needs of the entity's enrollees.

(iii) Are adopted in consultation with contracting health care professionals.

(iv) Are reviewed and updated periodically as appropriate.

(35) The requirements for quality assessment and performance improvement programs in this chapter may be found in their entirety in 42 CFR 438.240. An abbreviated list follows:

(a) Medicaid must require, through its contracts, that each entity has an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.

(b) At a minimum, Medicaid must require that each entity comply with the following requirements:

(i) Conduct performance improvement projects that are designed to achieve significant improvement in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

(ii) Submit performance measurement data to Medicaid annually.

(iii) Have in effect mechanisms to detect both underutilization and overutilization of services.

(iv) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

(36) The requirements for health information systems in this chapter may be found in their entirety in 42 CFR 438.242. An abbreviated list follows:

(a) Medicaid must ensure, through its contracts, that each entity maintains a health information system that collects, analyzes, integrates, and reports data.

(b) The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

(c) The entity must make all collected data available to Medicaid and upon request to CMS.

(37) The requirements for grievance systems in this chapter may be found in their entirety in 42 CFR 438.400. An abbreviated list follows:

(a) The Medicaid state plan provides an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.

(b) The Medicaid state plan provides for methods of administration that are necessary for the proper and efficient operation of the plan.

(c) Medicaid must require, through its contracts, that entities establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(d) In the case of an entity, *action* means:

(i) The denial or limited authorization of a requested service

(ii) The reduction, suspension, or termination of a previously authorized service.

(iii) The denial, in whole or in part, of payment for a service.

(iv) The failure to provide services in a timely manner as defined by the state.

(v) The failure of the entity to act within the timeframes provided in 438.408.

(e) *Appeal* means a request for review of an action, as "action" is defined above.

(f) *Grievance* means an expression of dissatisfaction about any matter other than an action, as "action" is defined above.

(38) The grievance system requirements in this chapter may be found in their entirety in 42 CFR 438.402. An abbreviated list follows:

(a) Each entity must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the state's fair hearing system.

(b) An enrollee, or a provider acting on behalf of the enrollee, may file an appeal, a grievance, or request a fair hearing.

(c) Medicaid will specify a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on the entity's notice of action.

(39) The requirements for notice of action in this chapter may be found in their entirety in 42 CFR 438.404. An abbreviated list follows:

(a) The notice must be in writing and must meet the language and format requirements of 438.10(c) and (d) to ensure ease of understanding

(b) The notice must explain the following:

(i) The action the entity or its contractor has taken or intends to take.

(ii) The reasons for the action.

(iii) The enrollee's or the provider's right to file an appeal.

(iv) The enrollee's right to request a state fair hearing.

(v) The procedures for exercising the rights specified in this section.

(vi) The circumstances under which expedited resolution is available and how to request it.

(vii) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(40) The requirements for the handling of grievances and appeals in this chapter may be found in their entirety in 42 CFR 438.406. An abbreviated list follows:

(a) In handling grievances and appeals, each entity must meet the following requirements:

(i) Give enrollees any reasonable assistance in completing forms and taking other procedural steps.

(ii) Acknowledge receipt of each grievance and appeal.

(iii) Ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making; or are health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.

(41) The requirements for resolution and notification of grievances and appeals may be found in their entirety in 42 CFR 438.408. An abbreviated list follows:

(a) The managed care entity must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within the timeframes established by the state.

(b) The entity may extend the timeframes by up to 14 days if the enrollee requests the extension; or the entity demonstrates that there is need for additional information and how the delay is in the enrollee's interest.

(42) The requirements for expedited resolution of appeals in this chapter may be found in their entirety in 42 CFR 438.410. Each entity must establish and maintain an expedited review process for appeals, when the entity determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health.

(43) The managed care entity must provide the information specified at 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

(44) Medicaid must require, through its contracts, each entity to maintain records of grievances and appeals and must review the information as part of the state quality strategy.

(45) The requirements concerning continuation of benefits (while an appeal or fair hearing is pending) in this chapter may be found in their entirety in 42 CFR 438.420. The managed care entity must continue the enrollee's benefits if:

(a) The enrollee or the provider files the appeal timely.

(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

(c) The services were ordered by an authorized provider.

(d) The original period covered by the original authorization has not expired.

(e) The enrollee requests extension of benefits.

(46) The requirements for effectuation of reversed appeal resolutions may be found in their entirety in 42 CFR 438.424.

(47) The requirements concerning fair hearings in this chapter may be found in their entirety in 42 CFR 431.200, et seq., and Chapter Three of this code. The Medicaid state plan must ensure that the regulations in these sections apply when a fair hearing is requested by an enrollee.

(48) The requirements concerning certifications and program integrity in this chapter may be found in their entirety in 42 CFR 438.600 through 438.610. An abbreviated list follows:

(a) When state payments to a managed care entity are based on data submitted by the entity, the state must require certification of the data as provided in 438.606.

(b) The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the state.

(c) The data submitted to the state must be certified by either the entity's chief executive officer, chief financial officer, or an individual who has been delegated the authority to sign for these officers.

(d) The certification must attest to the accuracy, completeness, and truthfulness of the submitted data.

(e) The entity must have procedures that are designed to guard against fraud and abuse.

(f) The entity must have written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.

(g) The entity may not knowingly have a relationship with an individual who is debarred, suspended, or otherwise excluded from participation in state or federal health care programs.

(49) The requirements concerning sanctions in this chapter may be found in their entirety in 42 CFR 438.700 through 438.730. An abbreviated list follows:

(a) Medicaid must establish, through its contracts with managed care entities, intermediate provider sanctions that may be imposed upon the state's findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(b) Medicaid may impose sanctions that include the following:

(i) Civil money penalties.

(ii) Appointment of temporary management for the entity.

(iii) Granting enrollees the right to terminate enrollment without cause.

(iv) Suspension of all new enrollment after the effective date of the sanction.

(v) Suspension of payment for recipients enrolled after the effective date of the sanction.

(50) The requirements concerning federal financial participation (FFP) in this chapter may be found in their entirety in 42 CFR 438.602 through 438.812. An abbreviated list follows:

(a) FFP is not available in an MCO contract that does not have prior approval from CMS.

(b) Under a risk contract, the total amount Medicaid pays for carrying out the contract provisions is a medical assistance cost.

(c) Under a nonrisk contract, the amount Medicaid pays for the furnishing of medical services to eligible recipients is a medical assistance cost; and the amount paid for the contractor's performance of other functions is an administrative cost.

(51) The requirements for timely processing of claims and cost-sharing in this chapter may be found in their entirety in 42 CFR 447.45 through 447.60. An abbreviated list follows:

(a) A contract with a managed care entity must provide that the entity will meet the requirements of 447.45 and abide by those specifications.

(b) The managed care entity and its providers may, by mutual agreement, establish an alternative payment schedule, which must be stipulated in their contract.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Social Security Act, Title XI and Title XIX, Section 1903(m) (2) (B); 42 C.F.R Section 434.26, Section 434.6; Part 438; Civil Rights Act of 1964, Titles VI and VII, as amended. The Federal Age Discrimination Act. Rehabilitation Act of 1973. The Americans with Disabilities Act of 1990.
History: Effective date July 12, 1996. Amended December 14, 2001. **Amended**: Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-37-.02 Primary Care Case Management (PCCM).

(1) Under this model of managed care, each patient/recipient is assigned to a primary medical provider (PMP) who in most cases is a physician who is responsible for managing the recipient's health care needs. This management function neither reduces nor expands the scope of covered services.

(a) PCCM services means case management related services that include location, coordination, and monitoring of primary health care services; and are provided under a contract between Medicaid and one of the providers listed in (2) below.

(b) PCCM services may be offered by the state as a voluntary option under the Medicaid state plan; or on a mandatory basis under a 1915(b) waiver.

(2) Primary Medical Providers (PMP)

(a) Physician PMPs are generally family practitioners, general practitioners, internists or pediatricians. If a patient's condition warrants, PMPs of another specialty may be assigned if he/she is willing to meet all contractual requirements. Patients may be assigned to the individual physician or a group of physicians.

(b) Clinics - In cases of Federally Qualified Health Centers (FQHCs) and Provider Based Rural Health Clinics (PBRHCs) and Independent Rural Health Clinics (IRHCs) patients will be assigned to the clinic.

(3) The Patient 1st PMP agrees to do the following:

a. Accept enrollees as a primary medical provider in the Patient 1st Program for the purpose of providing care to enrollees and managing their health care needs.

b. Provide Primary Care and patient coordination services to each enrollee in accordance with the provisions of the Patient 1st agreement and the policies set forth in the Alabama Medicaid Administrative Code, Medicaid provider manuals and Medicaid bulletins and as defined by Patient 1st Policy.

c. Provide or arrange for Primary Care coverage for services, consultation, management or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Patient 1st Policy.

d. Provide EPSDT services as defined by general Medicaid and Patient 1st Policy.

e. Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees as defined by Patient 1st Policy.

f. Maintain a unified patient medical record for each enrollee following the medical record documentation guidelines as defined by Patient 1st Policy.

g. Promptly arrange referrals for medically necessary health care services that are not provided directly, document referral for specialty care in the medical record and provide the authorization number to the referred provider.

h. Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of primary medical provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request. Enrollees can not be charged for copies.

i. Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Patient 1st Policy.

j. Refer for a second opinion as defined by Patient 1st Policy.

k. Review and use all enrollee utilization and cost reports provided by the Patient 1st Program for the purpose of practice level utilization management and advise the Agency of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Patient 1st Policy.

l. Participate with Agency utilization management, quality assessment, complaint and grievance, and administrative programs.

m. Provide the Agency, its duly authorized representatives and appropriate federal Agency representatives unlimited access (including on site inspections and review) to all records relating to the provision of services under this agreement as required by Medicaid policy and 42 C.F.R. 431.107.

n. Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by the Patient 1st Advisory Group.

o. Notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not made within 30 days of change , then future participation may be limited.

p. Give written notice of termination of this agreement, within 15 days after receipt of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis, by the PMP.

q. Refrain from discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.

r. Refrain from discriminating against individuals eligible to enroll on the basis of race, color, or national origin and will refrain from using any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

s. Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

t. Make oral interpretation services available free of charge to each potential enrollee and enrollee. This requirement applies to all non-English languages.

u. Receive prior approval from the Agency of any Patient 1st specific materials prior to distribution. Materials shall not make any assertion or statement (whether written or oral) that the recipient must enroll with the PMP in order to obtain benefits or in order not to lose benefits. Materials shall not make any assertion or statement that the PMP is endorsed by CMS, the Federal or State government or similar entity.

v. Refrain from door-to-door, telephonic or other 'cold-call' marketing or engaging in marketing activities that could mislead, confuse, or defraud Medicaid Recipients, or misrepresent the PMP, its marketing representatives, or the Agency.

w. Refrain from knowingly engaging in a relationship with the following:

- an individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;
- an individual who is an affiliate, as defined in the Federal Acquisition Regulation.

Note: The relationship is described as follows:

- As a director, officer, partner of the PMP,
- A person with beneficial ownership of more than five percent (5%) or more of the PMP 's equity; or,
- A person with an employment, consulting or other arrangement with the PMP for the provision of items and services that are significant and material to the PMP's contractual obligation with the Agency.

x. Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before the original 3 year period ends.)

y. Provide the Agency within 30 days notice of PMP disenrollment or change in practice site. This will allow for an orderly reassignment of enrollees. Failure to provide 30 days notice may preclude future participation and/or result in recoupment of case management fees.

(4) Recipients can choose or will be assigned to a PMP prior to the lock-in date to the PCCM program. Recipients have the ability to change PMPs on a monthly basis. Changes must be requested prior to the 20th of the month for the change to be effective the first of the following month.

(5) In order to participate in the PCCM system, a provider must sign an agreement with Medicaid that will detail the requirements of the PCCM system. PMPs will be paid a monthly medical

case management fee for primary care case management services in an amount determined by the Agency. The fee will be based on the number of recipients enrolled for the provider on the first day of each month.

(6) The Case Management fee will be automatically paid to the PMP on the 1st checkwrite of each month. The monthly case management fee will be determined by the components of care to which the PMP has agreed. Case Management fees will be adjusted quarterly. The monthly enrollment summary report will indicate the individual amount of case management fee being paid for that month. As additional case management components are offered, PMPs will be given the opportunity to decide participation. Case management fess are not subject to third party liability requirements as specified in 42 CFR 434.6(a)(9). All direct services are paid fee-for-service through medical claims processing procedures based on the regular Medicaid fee schedule. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) will not receive the case management fee each month.

(7) PMPs are limited to 1200 recipients unless additional numbers are approved by Medicaid. The Agency may increase the number of recipients based on historical caseload; documentation of a predominately Medicaid practice and/or employment of midlevel practitioners.

(8) The failure of a PMP to comply with the terms of this agreement or other provisions of the Medicaid Program governed under Social Security Act Sections 1932, 1903(m) and 1905(t) may result in the following sanctions by the Agency:

(a) Limiting member enrollment with the PMP.

(b) Withholding all or part of the PMP's monthly Patient 1st management/coordination fee.

(c) Referral to the Agency's Program Integrity or Quality Assurance Unit for investigation of potential fraud or quality of care issues.

(d) Referral to Alabama Medical Board or other appropriate licensing board.

(e) Termination of the PMP from the Patient 1st program.

One or more of the above sanctions may be initiated simultaneously at the discretion of the Agency based on the severity of the agreement violation. The Agency makes the determination to initiate sanctions against the PMP. The PMP will be notified of the initiation of a sanction by certified mail. Sanctions may be initiated immediately if the Agency determines that the health or welfare of an enrollee(s) is endangered or within a specified period of time as indicated in the notice. If the PMP disagrees with the sanction determination, he has the right to request an evidentiary hearing as defined by Patient 1st Policy.

Failure of the Agency to impose sanctions for an agreement violation does not prohibit the Agency from exercising its rights to do so for subsequent agreement violations.

Author: Kim Davis-Allen, Director, Medical Services
Statutory Authority: Sections 1915(b)(1)(2)(3), and (4): Sections 1902 (a)(i), (10) and (23) of the Social Security Act, 42 CFR 431.55; 438.2; 440.168.
History: **New Rule:** Filed June 21, 2004; effective September 15, 2004

Rule No. 560-X-37-.03 Prepaid Inpatient Health Plan (PIHP).

(1) A prepaid inpatient health plan (PIHP) is one that provides services to enrolled recipients on a capitated basis but does not qualify as a HMO.

(2) Capitated PIHPs do not need to meet the requirements of §1903(m)(2)(A) of the Social Security Act if services are less than fully comprehensive. Comprehensive services are defined as:

(a) Inpatient hospital services and one or more services or groups of services as follows:

(i) Outpatient hospital services;

(ii) Laboratory and X-ray services;
(iii) Nursing facility (NF) services
(iv) Physician services;
(v) Home health services;
(vi) Rural health clinic services;
(vii) FQHC services;
(viii) Early and periodic screening, diagnostic, and treatment (EPSDT) services; and
(ix) Family planning services.

(b) No inpatient services, but three or more services or groups of services listed in Section (2)(a).

(3) If inpatient services are capitated, but none of the additional services listed in Section (2)(a) above are capitated, the entity may be considered a PIHP.

(4) The Partnership Hospital Program (PHP) is a non-comprehensive Prepaid Inpatient Health Plan (PIHP) operating under the Medicaid state plan. The following further describes the Partnership Hospital Program:

(a) It is an inpatient care program.

(b) It is mandatory for Medicaid recipients, with the exception of recipients with Part A Medicare coverage, SOBRA adults who are enrolled in and receive inpatient care through the Maternity Care program in counties covered by the PHP, and children certified through the Children's Health Insurance Program (CHIP).

(c) It is composed of prepaid inpatient health plans organized by districts in the State of Alabama.

(d) PIHPs operate under the authority granted in the Partnership Hospital Program, a state plan service as approved by CMS.

(e) Medicaid reimburses the prepaid inpatient health plans participating in the Partnership Hospital Program on a per member per month capitation basis.

(f) Prepaid inpatient health plans provide medically necessary inpatient care for covered Medicaid recipients including:

(i) Bed and board
(ii) Nursing services and other related services
(iii) Use of hospital facilities
(iv) Medical social services
(v) Drugs, biologicals, supplies, appliances and equipment
(vi) Certain other diagnostic and therapeutic services, and
(vii) Medical or surgical services provided by certain interns or residents-in-training.
(viii) Excluded are inpatient family planning services and inpatient emergency services.

(g) Prepaid inpatient health plans will assist the participant in gaining access to the health care system and will monitor on an inpatient basis the participant's condition, health care needs, and service delivery.

(h) Prepaid inpatient health plans are responsible for locating, coordinating, and monitoring all inpatient care in acute care hospitals within the state.

(i) Systems required of prepaid health plans, at a minimum, include:

(i) Quality assurance and utilization review systems
(ii) Grievance systems
(iii) Systems to furnish required services, including utilization review
(iv) Systems to prove financial capability
(v) Systems to pay providers of care

(5) The PIHP and Medicaid shall operate a quality assurance (QA) program sufficient to meet those quality review requirements of 42 CFR Part 438, Subpart D, applicable to PIHPs and their providers. The QA Program and any revisions must be approved in writing by Medicaid.

(a) The PIHP shall appoint a QA Committee to implement and supervise the QA Program. This committee shall consist of not less than three healthcare professionals, who may be members of the PIHP board, employees of providers or such other persons in the healthcare field as the PIHP believes will be required to oversee the creation and control of a successful QA Program for the PIHP.

(b) The QA Program shall be a written program specifying:

(i) Utilization control procedures for the on-going evaluation, on a sample basis, of the need for, and the quality and timeliness of care provided to Medicaid eligibles by the PIHP.

(ii) Review procedures by appropriate health professionals of the process, following the provision of health services.

(iii) Procedures for systematic data collection of performance and patient results.

(iv) Procedures for interpretation of these data to the provider.

(v) Procedures for making needed changes.

(c) The QA Committee shall employ a professional staff to obtain and analyze data from Medicaid information systems, the provider hospitals, and such other sources as the staff deems necessary to carry out the QA Program. All costs of the QA Program shall be paid by the PIHP.

(d) PIHP member hospitals shall conduct continuing internal reviews of their own QA programs. The QA Committee staff shall be given all such assistance and direction by such provider QA programs and shall obtain such reasonable information from such providers as may be necessary to implement the PIHP QA Programs.

(e) The staff shall implement such focused medical reviews of the providers as may be required by Medicaid, required under the QA Program, or believed necessary the staff.

(f) Medicaid staff shall coordinate with the PIHP's QA Committee and staff on QA matters. Medicaid shall make such audits and surveys as it deems reasonably required, but shall do at least one annual medical audit on each PIHP and all of its providers. The PIHP shall provide all information, medical records, or assistance as may be reasonably required for Medicaid to conduct such audits.

(g) Medicaid QA personnel will make periodic on-site visits to review and monitor the QA Program and assess improvements in quality. The PIHP shall make certain all necessary information and records are available at such sites.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Part 434 and 438; State Plan Attachment 4.19-A(f)
History: Rule amended July 12, 1996. Emergency rule effective October 1, 1996. Amended January 14, 1997; January 12, 1998; June 16, 2003.
Amended: Filed April 7, 2004; effective July 16, 2004.

Rule No. 560-X-37-.04 Health Maintenance Organizations (HMO).

(1) Health Maintenance Organizations (HMO~~s~~) means any entity or corporation that undertakes to provide or arrange for basic health care services through an organized system which combines the delivery and financing of health care to enrollees. The organization shall provide physician services directly through physician employees or under contractual arrangements with either individual physicians or a group of physicians. The organization shall provide basic health care services directly or under contractual arrangements. When reasonable and appropriate, the organization may provide physician services and basic health care services through other arrangements. The organization may provide, or arrange for, health care services on a prepayment or other financial basis.

(2) Covered services shall be provided to each eligible enrollee and will be reimbursed on a monthly capitation basis.

(3) The HMO is required to obtain a Certificate of Authority to operate as a HMO in the State of Alabama, issued by the Department of Insurance prior to providing services. HMOs must obtain a Certificate of Need (CON) or a letter of non-reviewability from the State Health Planning Agency. When

applicable, the HMO may also be required to participate in an Invitation to Bid process as directed by the Medicaid Agency.

(4) The HMO shall make adequate provisions against the risk of insolvency as contained in the Code of Alabama Section 27-21A-12 and as specified in the contract between the HMO and Medicaid. The HMO must ensure that individuals eligible for benefits are never held liable for debts of the plan.

(5) HMOs desiring to participate as a managed care provider should contact the Medical Services Division at Medicaid. HMOs must submit written documentation for approval which includes, but is not limited to, the following:

(a) Description of services to be provided
(b) Marketing Plan and any marketing materials to be used by the plan
(c) Quality Assurance Plan
(d) Enrollment Plan
(e) Education Plan
(f) Copy of Certificate of Authority
(g) Copy of Certificate of Need or letter of non-reviewability
(h) Examples of subcontracts to be utilized by the plan
(i) Proposed enrollment sites
(j) Enrollment area
(k) Grievance procedures

All of the above information must be sent before the review can be completed.

(6) The HMO must ensure contracted health services required by the enrollees are available and accessible through a system that arranges for primary and preventive care provided by and coordinated through a Medicaid enrolled Primary Care Physician (PCP).

(7) Enrollment

(a) In geographical areas that are served by a freedom-of-choice waiver, enrollment in an approved HMO is mandatory for those recipients included in the waiver. Recipients will have the opportunity to voluntarily enroll in an HMO during the open enrollment period, if applicable.

(b) In the event that a recipient who resides in an area that has a freedom-of-choice waiver does not select an HMO, Medicaid will mandatorily assign that recipient to an HMO. In an area where only one HMO is operational under an approved 1115 waiver, the recipient will be required to select a PCP within the HMO's network or be assigned. This will be done according to a formula which meets the needs of the State and the recipients and which is communicated to all health plans in advance. This formula may consist of rotation among the HMOs. Medicaid will notify the HMO of the recipients mandatorily enrolled in their plan via computer compatible media. Recipients that have been mandatorily assigned will also be notified by Medicaid. The effective date of enrollment generally will be the first day of the month following a full calendar month after assignment to an HMO. It is the HMO's responsibility to send to Medicaid monthly, on computer compatible media, all current enrollees, new enrollees and disenrollments.

(8) Disenrollment

(a) When an enrollee becomes ineligible for Medicaid benefits, is deceased, moves out of the service area, or is changed to a non-covered aid category; the effective date of disenrollment will be the first day of the month following documentation of the change on the Managed Care File.

(b) Any enrollee may elect to disenroll from an HMO, with or without cause, and enroll in another where multiple HMOs participate in the Medicaid program in that area. Recipients are required to submit a written disenrollment request to the HMO with a reason documented in the patient file and on the monthly enrollment information. Disenrollment is effective the first day of the month following a full calendar month after receipt of the disenrollment on the monthly enrollment information.

(c) Unless otherwise specified in an approved waiver, an HMO may disenroll an enrollee whose behavior is disruptive, unruly, abusive, or uncooperative, and not caused by a medical condition, to the extent that his membership in the HMO seriously impairs the HMO's ability to furnish services to that enrollee or other members of the HMO. The HMO is required to provide at least one verbal and one written warning to the enrollee regarding the implication of his actions. No member can be involuntarily disenrolled without the prior written approval of Medicaid.

(d) Unacceptable reasons for an HMO to disenroll an enrollee include pre-existing medical conditions, changes in health status, and periodic missed appointments.

(e) Enrollees may be disenrolled for knowingly committing fraud or permitting abuse of their Medicaid card. Disenrollment of this nature must be promptly reported to Medicaid and must be prior authorized by Medicaid.

(f) The HMO's responsibility for all disenrollments includes supplying disenrollment forms to enrollees desiring to disenroll; ensuring that completed disenrollment forms are maintained in an identifiable enrollee record; ensuring that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so; and ensuring that disenrollees receive written notification of the effective date of and reason for disenrollment. HMOs must submit voluntary disenrollments on the first electronic submission sent to Medicaid after the request is received by the HMO.

(9) Marketing

(a) The Medicaid Agency may elect to enroll recipients through contracted enrollment vendors. If the State chooses to use vendors, HMOs will not be allowed to enroll or recruit patients through marketing representatives.

(b) The HMO shall submit the written marketing plan, procedures, and materials to Medicaid for approval prior to implementation. Enrollment of recipients may not begin until the marketing plan has been approved by Medicaid.

(c) The HMO shall not engage in marketing practices that mislead, confuse, or defraud enrollees, providers, or Medicaid. Mailings, gifts of a material nature, telecommunication and door-to-door marketing are subject to prior approval by the Alabama Medicaid Agency.

(d) Accurate, clear, readable, and concise information shall be made available to eligible recipients and providers in the area serviced by the HMO. Such information shall include, but not be limited to: covered services, location, telephone number, hours of service, enrollment, disenrollment, grievance procedures, and what to do in case of an emergency.

(e) No more than fifty percent (50%) of a marketing representative's total annual compensation, including salary, benefits, bonuses and commission, shall come from commissions.

(10) Grievance Procedures

(a) The HMO shall have a written internal grievance procedure that is approved by Medicaid.

(b) The HMO must have written procedures for prompt and effective resolution of written enrollee grievances.

(c) The HMO must include a description of the grievance system including the right to appeal decisions.

(d) The HMO must maintain records of all oral complaints and written grievances in a log (hard copy or automated).

(e) The HMO must make provisions to accept and resolve grievances filed by individuals other than enrollees.

(11) Quality Assurance

(a) The HMO's Quality Assurance Plan (QAP) must objectively and systematically monitor and evaluate the quality and age appropriateness of care and services through quality of care studies and related activities by following written guidelines predicated on the Quality Assurance Reform Initiative (QARI) which must include:

(i) Goals and objectives;
(ii) Scope;
(iii) Specific activities;
(iv) Continuous activities;

(v) Provider review; and
(vi) Focus on health outcomes.

(b) The Governing Body of the HMO must be responsible for, or designate an accountable entity within the organization to be responsible for, oversight of the QAP.

(c) Each HMO must designate a committee responsible for the performance of QA functions accountable to the Governing Body.

(d) The QAP must objectively and systematically monitor and evaluate the quality and appropriateness of care and service through quality of care studies and related activities.

(e) Each HMO must designate a senior executive to be responsible for QAP implementation and the Medical Director must have subsequent involvement in QAP activities.

(f) The QA Committee must have, as members HMO providers representative of the composition of all providers of service.

(g) The QAP must include provisions for credentialing and recredentialing of health care professionals who are licensed by the State.

(h) HMOs shall allow Medicaid's authorized representative, on an annual basis, to conduct an external independent quality review to analyze the quality of services furnished by the HMO to ensure adequate delivery of care. The results of the review shall be made available to Medicaid, and upon request, to the Secretary of HHS, the Inspector General, and the Comptroller General.

(12) Records

(a) An appropriate record system shall be maintained for all services (including ancillary services) provided to all enrollees. Such records shall be stored in a safe manner to prevent damage and unauthorized use. Records will be reasonably accessible for review.

(b) Entries on medical records shall be authenticated and written legibly in ink or typewritten.

(c) Records must contain all pertinent information relating to the medical management of each enrollee reflecting all aspects of patient care in a detailed, organized and comprehensive manner consistent with medical practice standards.

(d) The HMO shall make available at no cost to Medicaid, the Department of Health and Human Services, and to their designees, any records of the provider and/or subcontractors which relate to the HMO's ability to bear risks for the services performed, amounts paid for benefits, quality review, and any other requested documentation.

(13) Reporting

(a) The HMO shall furnish any information from its records to HHS, the Comptroller General, and/or their agents which may be required to administer the contract. At a minimum, the HMO shall furnish to Medicaid, and to authorized representatives, in a manner and form specified by Medicaid:

(i) Business transactions to include:

a. Any sale, exchange or lease of any property between the HMO and a party in interest;

b. Any lending of money or other extension of credit between the HMO and a party in interest; and

c. Any furnishing for consideration of goods, services (including management services) or facilities between the Plan and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions listed above between an HMO and a party in interest includes the name of the party in interest for each transaction, a description of each transaction and the quality of units involved, the accrued dollar value of each transaction during the fiscal year and justification of the reasonableness of each transaction.

(ii) Proposed changes to the marketing plan, procedures or materials;
(iii) Monthly enrollment data to include name, Medicaid number, payee number, and PCP assignment number;
(iv) Utilization data concerning enrollees in the Plan as required by contract;

(v) Summaries of all complaints and all grievances received by the HMO under this contract and actions taken to resolve complaints and grievances quarterly and annually.

(vi) Summaries of amounts recovered from third parties for services rendered to enrollees under the HMO;

(vii) A list of payments made by the HMO during the past month for services purchased through referral and subcontracted providers;

(viii)Encounter data claims submitted directly to Medicaid's fiscal agent for all services paid for or provided by the HMO to enrollees in previous months; and

(x) All other reports as specified and defined in the Managed Care Provider Manual/Operational Protocol and contract.

(b) The HMO will keep and make available to Medicaid, HHS, the Comptroller General, and their agents or authorized representatives, any of the HMO's records which are necessary to fully disclose and substantiate the nature, quality, cost, and extent of items and services provided to enrollees. The HMO shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of five years from the date of the last payment made by Medicaid to the HMO under this contract. However, when audit, litigation, or other action involving records is initiated prior to the end of the five (5) years period, records shall be maintained for a period of five (5) years following the completion of such action and the resolution of all actions which arise from it. Plans shall fully complete and submit to Medicaid quarterly financial statements. Quarterly reports are due for periods ending March 31, June 30, September 30, and December 31 and must be submitted within 45 days of the end of the reporting period or the HMO shall pay a penalty of $100.00 for each day the financial report is delinquent. In addition, the National Association of Insurance Commissioner's Annual Statement Blank, must be fully completed by Contractor annually and submitted to Medicaid. The HMO's annual report must be submitted no later than March 1 or Contractor shall pay to Medicaid a penalty of $100.00 for each day the annual report is delinquent. However, the Commissioner of Medicaid shall have the option to waive the penalty with shown proof by the HMO of good cause for the delay. In addition, the HMO must submit an audited financial statement to Medicaid covering the fiscal year within 90 days of the end of its fiscal year. Contractor shall also promptly submit any and all other financial information requested by Medicaid, HHS, or the Comptroller General.

(14) Payment

(a) Capitation payments to the HMO for all eligible enrollees shall be made monthly.

(b) The HMO shall accept the capitation fees as payment in full for Medicaid benefits provided and shall require its providers to accept payments in full for Medicaid benefits provided.

(c) Neither managed care enrollees nor Medicaid shall be held liable for debts of the HMO in the event of the organization's insolvency.

(d) In-plan covered services must be provided by the HMO chosen by the recipient. These services can be provided directly, through subcontract providers, or by non-contract out-of-plan providers when appropriately referred.

(e) If an enrollee utilizes a non-contract provider for in-plan service, other than emergency services, family planning services, and services provided by a Federally Qualified Health Center (FQHC), the HMO, to the extent allowed by law, may not be held liable for the cost of such utilization unless the HMO referred the enrollee to the non-contract provider or authorized the out-of-plan utilization. Payment by the referring HMO for properly documented claims shall not exceed the maximum fee-for-service rates applicable for the provider for similar services rendered under the Alabama Medicaid Program, unless otherwise agreed upon by the HMO and the non-contract provider. No reimbursement shall be available directly from Medicaid for in-plan services provided by non-contract providers. If there is an FQHC in the geographical area being served by a HMO that contracts with one or more HMO's, an enrollee may elect to join the HMO contracting with the FQHC in order to receive the services offered by the FQHC. If no FQHC in the area agrees to contract with any of the HMOs, the HMOs are obligated to reimburse the FQHC if an enrollee elects to receive services from this entity.

(15) Compliance Review Committee

(a) Alabama Medicaid shall establish a Compliance Review Committee (CRC). The purpose of the CRC is to facilitate resolution of issues related to compliance with the requirements of the contract between the HMO and Medicaid.

(b) Administrative sanctions are reserved for managed care program abuses. Sanctions may be imposed by the Agency for failure to comply with Agency program requirements.

(c) In all cases of HMO abuse, restitution of improper payments or monetary sanctions may be pursued in addition to any administrative sanctions imposed. Administrative sanctions include, but are not limited too, probation. During probation, an HMO may have the number of enrollees it serves limited to a fixed number by the Agency for a set period of time. The HMO will be notified if probation has been authorized for a specific period of time and at the termination of the probation, the HMO will be subject to a follow-up review of its Medicaid Managed Care practice.

(d) The decision as to the sanction(s) to be imposed shall be at the discretion of the Medicaid Commissioner based on the recommendation(s) of the staff of the Managed Care Division, the CRC or other appropriate program review personnel.

(e) The following factors shall be considered in determining the sanctions to be imposed:

(i) Seriousness of the offense(s)

(ii) Extent of violations and history of prior violations

(iii) Prior imposition of sanctions

(iv) Actions taken or recommended by Peer Review Organizations or licensing boards

(v) Effect on health care delivery in the area

When an HMO is reviewed for administrative sanctions, the Agency shall notify the HMO of its final decision and the HMO's entitlement to a hearing in accordance with the Alabama Administrative Procedure Act.

(16) Childrens Health Insurance Program (CHIP)

Children eligible as CHIP children, aged up to 19, who reside in counties in which HMO coverage is available may be included in the program.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Alabama State Plan for Medical Assistance (hereinafter State Plan), Section 2.1(c), Attachment 2.1-A; Attachment 4.18-A; Social Security Act, Title XI and Title XIX, Section 1903(m); 42 C.F.R. Section 434 et seq.; Civil Rights Act of 1964, Titles VI and VII, as amended. Code of Alabama 1975, Section 22-21-20, et seq., Section 27-21A-1, et seq., and 41-22-1, et seq. The Federal Age Discrimination Act. Rehabilitation Act of 1973. The Americans with Disabilities act of 1990.
History: Effective date is July 12, 1996. Amended January 12, 1998. **Amended**: Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-37-.05 Medicare Health Maintenance Organizations (MHMOs) and Competitive Medical Plans (CMPs).

(1) A Medicare Health Maintenance Organizations (MHMO) and Competitive Medical Plans (CMP) are organizations which may contract with the Health Care Financing Administration (HCFA) to enroll Medicare beneficiaries and other individuals and groups to deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to its Medicare enrollees. An HMO or CMP must be organized under the laws of the State and must meet HCFA's qualifying criteria, as specified in 42 C.F.R. §417.410-.418, in order to enter into a contract with HCFA to enroll Medicare beneficiaries.

A Competitive Medical Plan, as defined in 42 C.F.R. §417.407(c), is a legal entity, which provides to its enrollees at least the following services: services performed by physicians; laboratory, x-ray, emergency, and preventive services; out-of-area coverage; and inpatient hospital services. The entity receives compensation by Medicaid for the health care services it provides to enrollees on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any enrollee. The entity provides physician services primarily through physicians who are employees or partners of the entity or physicians or groups of physicians (organized on a group or individual practice basis) under

contract with the entity to provide physician services. The entity assumes full financial risk on a prospective basis for provision of health care services, but may obtain insurance or make other arrangements as specified in 42 C.F.R. §417.120 and .407. The entity must provide adequately against the risk of insolvency by meeting the fiscal and administrative requirements of 42 C.F.R. §417.120(a)(1)(i) through (a)(1)(iv) and 417.122(a).

(2) The Alabama Medicaid Agency may reimburse a fixed per member per month (PMPM) capitated payment established by Medicaid to HMOs and CMPs which have an approved Medicare risk contract with the Health Care Financing Administration for beneficiaries who enroll in a Medicare HMO or CMP for which Medicaid is responsible for payment of medical cost sharing. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. This PMPM payment will cover, in full, any premiums or cost sharing required from the Medicare Plan. The PMPM payment will be established based on historical costs and negotiations.

(3) Medicare HMOs and CMPs may enroll with the Medicaid Agency to receive capitated payments for beneficiary premiums and cost sharing by executing a Memorandum Of Understanding with the Medicaid Agency. To enroll the following must be submitted to Medicaid:

(a) A copy of HCFA approval for a Medicare risk contract to enroll Medicare beneficiaries;

(b) A copy of the HMO or the CMP's member services handbook; and

(c) A copy of Certificate of Authority (COA) from the Alabama Insurance Department and appropriate approvals for a material modification to a COA.

(4) All services covered by Medicare shall be covered by the HMO or CMP at no cost to the beneficiary. In addition, the HMO or CMP may offer additional services to the beneficiary (e.g. hearing exams, annual physical exam, eye exams, etc.). The HMO or CMP must notify the Alabama Medicaid Agency prior to adding additional services (identified by procedure code) available to the beneficiary through the Plan. Services covered directly by Medicaid which are not covered by Medicare are not included in the Plan.

(5) The beneficiary will be given freedom of choice in selecting a primary care provider through the Medicare HMO or CMP.

(6) The Medicare HMO or CMP is required to submit a monthly electronic enrollment listing to Medicaid in a format specified by Medicaid.

Authority: State Plan 3.2(a)(10)(E)(i). Social Security Act §1905(p)(1). 42 C.F.R. Section 434.20, Section 434.26, Section 434.23, Section 434.29, Section 434.38, Section 434.6. Effective date is July 12, 1996.

Rule No. 560-X-37-.06 - Family Planning Waiver.

(1) The Family Planning Waiver program operates under an approved Section 1115(a) Research and Demonstration Waiver, which extends Medicaid eligibility for family planning services to all women of childbearing age (19 through 44), with incomes at or below 133% of the federal poverty level who would not otherwise qualify for Medicaid. The waiver has been approved for five (5) years and may be renewed with HCFA's approval.

(2) The program represents a collaborative effort between the Alabama Medicaid Agency and the Alabama Department of Public Health.

(3) The Family Planning Waiver Program is officially known as the "Plan First Program."

(4) Enrolled Medicaid providers are eligible to provide family planning services but must also enroll as a network provider by completing a Plan First agreement. Upon receipt of the signed

agreement, Medicaid's fiscal agent will add the Plan First provider specialty code to the provider's existing record. Those providers that only do tubal ligations do not have to enroll as a Plan First provider nor do anesthesia providers for these procedures. There are no changes to current provider eligibility policies due to this waiver.

(5) The following are the eligible groups for the Family Planning Waiver:

(a) Women age 19 through 44 who have SOBRA eligible children will become automatically eligible for family planning without a separate eligibility determination. Women who are not citizens and are payees of SOBRA Medicaid children will be sent a letter along with an application telling them how to apply for the Plan First Program.

(b) SOBRA poverty level pregnant women age 19 through 44 will receive automatic eligibility for family planning services at the expiration of their 60 days postpartum without separate eligibility determination.

(c) Other women age 19 through 44 who are not pregnant and are not applying for a child may apply for family planning services using a simplified shortened application.

(d) SOBRA females who are turning age 19 and would ordinarily be terminated from Medicaid.

Newly awarded family planning recipients will receive a Medicaid plastic card based on the same criteria as other Medicaid recipients. Providers will be informed at the time of eligibility verification that services are limited to family planning only. If a recipient has received a plastic card in the recent past, another card will be sent only upon request.

(6) In order to be eligible for Family Planning Services a woman must:

(a) Furnish a Social Security number or proof they have applied for one

(b) Be a female resident of Alabama age 19 through 44

(c) Meet citizenship and alienage requirements

(d) Have family income at or below 133% of the federal poverty level

(e) Cooperate in establishing third party medical benefits, and apply for all benefits to which she may be entitled

(7) Once determined eligible, a woman will remain eligible for benefits until the termination of the waiver unless she disenrolls or is terminated from the waiver for one of the following reasons:

(a) The recipient's gross countable family income exceeds 133% of the federal poverty level

(b) The recipient does not reside in Alabama

(c) The recipient is deceased

(d) The recipient has received a sterilization procedure

(e) The recipient requests her family planning benefits be terminated

(f) The recipient is outside the family planning age limit of 19 through 44

(g) The recipient is eligible for Medicare benefits

(h) The recipient becomes eligible for another Medicaid program

(i) The recipient fails to cooperate with the Medicaid Agency in the eligibility process, receipt of services or Medicaid Quality Control Review

(j) The recipient is determined ineligible due to fraud, misrepresentation of facts, or incorrect information

(8) Medical services covered for the extended eligibles are limited to birth control services and supplies only. This includes:

(a) All currently covered family planning methods

(b) Outpatient tubal ligation

(c) Doctor/clinic visits (for family planning only)

(d) HIV pre and post test counseling visits

(9) Eligible participants have freedom of choice in the selection of an enrolled network provider. Oral contraceptives must be received from an in-network provider, not from a pharmacy. Network providers may dispense only those oral contraceptives that are on the Alabama Department of Public Health's formulary. Requests from providers for oral contraceptives not on the Health Department's formulary will be reviewed and a decision will be made based on medical necessity of an alternate oral contraceptive.

(10) Oral contraceptives that are dispensed by network providers must be ordered from the Alabama Department of Public Health and must be dispensed only to waiver participants. Stock for waiver participants should be maintained separately from sample stock. Orders should be placed using the "Oral Contraceptives Order Form" provided to network providers and orders should be placed for a three (3) month period and re-ordered when the provider is down to a 30-day supply. Orders will be processed by the Alabama Department of Public Health within five (5) working days of receipt of order form. Order forms will be accepted by general mail or fax.

(11) Under this waiver, Medicaid also reimburses for care coordination activities provided by licensed social workers or registered nurses associated with the Alabama Department of Public Health who have received training on the Family Planning Program. Services are available to all women, regardless of the care site. Care coordination will be reimbursed on a per hour basis in 5 minute increments. Enrolled providers must refer participants to the Health Department to initiate care coordination.

(12) Family Planning Care Coordination will only be available for women eligible through the Family Planning Waiver. Recipients eligible for other Medicaid eligibility programs will be eligible for the regular benefit packages established for those programs and will not be eligible for the enhanced family planning care coordination services.

(13) The Family Planning Waiver program operates under approved Terms and Conditions as specified in the waiver and the Operational Protocol Manual.

Author: Kim Davis-Allen, Director, Medical Services Division.
Statutory Authority: Section 1115(a): Sections 1902(a) (10) (b), (e) (5) and (6) of the Social Security Act.
History: New Emergency Rule filed: August 28, 2000; effective October 1, 2000. Amended: Filed September 21, 2000, effective December 11, 2000. Amended: Filed September 21, 2001, effective December 14, 2001.

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Chapter 38. Ambulatory Surgical Center Services

Rule No. 560-X-38-.01. General.

1. Ambulatory surgical services are those procedures typically performed on an inpatient basis which can be performed safely on an outpatient or ambulatory surgical center (ASC) basis.
2. Ambulatory surgical center services shall be reimbursed by means of a predetermined fee established by the Alabama Medicaid Agency. All ambulatory surgical center procedures shall be reimbursed at the lesser of the predetermined rate for the procedure less the copay amount. The fee is established at levels estimated to approximate the costs incurred by providers generally in providing covered services.
3. Ambulatory surgical center services shall be limited to three (3) visits per calendar year.

Authority: 42 C.F.R. Sections 416.2, 416.39, and 416.40. Rule effective September 1, 1986.

Rule No. 560-X-38-.02. Participation.

1. In order to participate in the Title XIX Medicaid Program and to receive Medicaid payment for services, ASC providers must meet all of the following requirements:
   - (a) Certification for participation in the Title XVIII Medicare Program;
   - (b) Approval by the appropriate licensing authorities;
   - (c) Compliance with Title VI of the Civil Rights Act of 1964 and with Section 504 of the Rehabilitation Act of 1973; and
   - (d) Submit a letter requesting enrollment, a copy of a transfer agreement with an acute care facility (refer to Rule No. 560-X-38-.05 for details), and enter into a contract with the Alabama Medicaid Agency.
   - (e) Reimbursement is limited to services provided directly by the facility's staff in accordance with the capability as specified on the HCFA-377.
2. The fiscal agent will be responsible for enrolling any Title XVIII (Medicare) certified Ambulatory Surgery Centers that wish to be enrolled as Qualified Medicare Beneficiary (QMB) only providers.

Authority: 42 C.F.R. Section 416.2, Section 416.39, and Section 416.40. Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360). Rule effective September 1, 1986. Rule amended July 13, 1989. Effective date of this amendment September 11, 1992.

Rule No. 560-X-38-.03. Payment.

1. Payment shall be made for a surgical procedure performed on a Medicaid recipient only if the procedure is on the approved list.
2. Ambulatory surgical center services are items and services furnished by an outpatient ambulatory surgery center in connection with a covered surgical procedure.
3. Rates of reimbursement for ambulatory surgical center services include, but are not limited to:
   - (a) Nursing, technician and related services;
   - (b) Use of an ambulatory surgery center;
   - (c) Lab and x-ray, drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision(s) of the surgical procedure(s);
   - (d) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
   - (e) Administrative, record keeping, and housekeeping items and services; and

(f) Materials for anesthesia.

4. Ambulatory surgical center services do not include items and services for which payment may be made under other provisions. Ambulatory surgical center services do not include:
   - (a) Physician services;
   - (b) Lab and x-ray not directly related to the surgical procedure;
   - (c) Diagnostic procedures (other than those directly related to performance of the surgical procedure);
   - (d) Prosthetic devices (except intraocular lens implant);
   - (e) Ambulance services;
   - (f) Leg, arm, back, and neck braces;
   - (g) Artificial limbs; and
   - (h) Durable medical equipment for use in the patient's home.

Authority: State Plan, Attachment 3.1-A; 42 C.F.R. Section 416.61, Section 416.65, and Section 416.120. Rule effective September 1, 1986. Effective date of this amendment March 12, 1988.

Rule No. 560-X-38-.04. Covered Surgical Procedures

1. Covered surgical procedures are those procedures that meet the following standards:
   - (a) Those surgical procedures which are commonly performed on an inpatient basis in hospitals, but may be safely performed in an ambulatory surgical center setting;
   - (b) Those surgical procedures which are limited to those requiring a dedicated operating room and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room; and
   - (c) Those surgical procedures which are not otherwise excluded under 42 C.F.R. Section 405.310 or other regulatory requirements.
2. A listing of the covered surgical procedures shall be maintained by the Alabama Medicaid Agency and shall be furnished to all ASCs. This list shall be reviewed and updated on a regular basis by the appropriate staff of the Alabama Medicaid Agency.

Authority: 42 C.F.R. Section 405.310 and Section 416.65. Rule effective September 1, 1986.

Rule No. 560-X-38-.05. Ambulatory Surgical Center Transfer Procedures.

The ambulatory surgical centers shall have an effective procedure for the immediate transfer to a hospital of patients requiring emergency medical care beyond the capabilities of the center. The hospital shall have a provider contract with the Alabama Medicaid Agency. The center shall have a written transfer agreement with said hospital, and each physician performing surgery in the center shall have admitting privileges at said hospital. The center shall furnish the Alabama Medicaid Agency with evidence of such prior to its enrollment. Changes in this submitted information will also be made available to the Medicaid Agency.

Authority: 42 C.F.R. Section 416.41. Rule effective September 1, 1986.

Rule No. 560-X-38-.06. Surgical Procedures Groups.

The surgical procedures shall be classified into separate payment groups. All procedures within the same payment group are reimbursed at a single rate. These rates are subject to adjustment by the Alabama Medicaid Agency. The group payment amount is lowest for Group One procedures and highest for Group Four. A provider shall receive the lesser of the submitted charge or the designated group charge less the copay amount.

Authority: 42 C.F.R. Section 405.310 and Section 416.65. Rule effective September 1, 1986.

Rule No. 560-X-38-.07. Submission of Claims.

1. Ambulatory surgical center services are treated as medical services and UB82 claim forms shall be submitted for payment listing facility provider number and utilizing HCFA Common Procedure Coding System (HCPCS) and indicating an ICD-9-CM diagnosis code.
2. If one covered surgical procedure is furnished to a Medicaid recipient in an operative session, payment shall be at the lesser of the submitted charges, or l00 percent of the predetermined rate for the procedure.
3. If more than one covered surgical procedure is furnished to a Medicaid recipient in a single operative session, payment shall be made at the lesser of the submitted charges, or at the full amount for the procedure with the higher predetermined rate less the copay amount. Other covered surgical procedures furnished in the same session will be reimbursed at the lesser of the submitted charges, or at 50 percent of the predetermined rate for each of the other procedures.

Authority: 42 C.F.R. Section 416.120. Rule effective September 1, 1986.

Rule No. 560-X-38-.08. Patient Signature.

Refer to Chapter One of the Alabama Medicaid Administrative Code Rule 560-X-1-.18(5)(a), as amended.

Authority: State Plan; Title XIX, Social Security Act; Alabama Medicaid Agency Administrative Code. Rule effective September 1, 1986.

Rule No. 560-X-38-.09. Billing and Sending Statement to Eligible Alabama Medicaid Recipients.

1. No eligible Alabama Medicaid recipient shall receive a bill or statement for covered services or items once the recipient has been accepted as a Medicaid patient. A recipient may be billed by the provider for noncovered services or items.
2. The provider may send a notice to the recipient stating the recipient's claim is outstanding provided the notice indicates in bold letters: "THIS IS NOT A BILL."
3. It is the responsibility of the provider to pursue any unpaid claim with the fiscal agent and/or Medicaid involving Medicaid covered services.
4. No recipient is responsible for the difference between the covered charges billed and the amount paid by Medicaid for covered charges. A provider agrees to accept as payment in full the amount paid by Medicaid for covered services, and further agrees to make no additional charge(s) for covered services to the recipient, sponsor, or family of the recipient.

Authority: State Plan, Title XIX Social Security Act, 42 C.F.R. Section 447.15, Section 447.50, and Section 447.55. Rule effective September 1, 1986.

Rule No. 560-X-38-.10. Copayment (Cost-Sharing).

1. Medicaid recipients are required to pay, and ambulatory surgery center providers are required to collect, the designated copayment amount for each visit. Refer to Rule #560-X-1-.25 General Chapter for copay information.
2. A provider may not deny services to any eligible individual due to the individual's inability to pay the cost-sharing amount imposed.

Authority: State Plan, Attachment 4.18-A, Title XIX, Social Security Act, 42 C.F.R. Section 447.50, Section 447.55, and Section 447.15. Rule effective September 1, 1986.

Chapter 39. Extracorporeal Shock Wave Lithotripsy (ESWL)

Rule No. 560-X-39-.01. General.

1. ESWL is a covered benefit for treatment of kidney stones in the renal pelvis, uretero-pelvic junction, and the upper one-third of the ureter.
2. ESWL is not a covered service for urinary stones of the bladder and the lower two-thirds of the ureter.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. §482.11, 482.12, 482.22, 482.54. Rule effective October 13, 1987. Rule amended December 14, 1990. Emergency rule effective February 4, 1991. Amendment effective May 14, 1991.

Rule No. 560-X-39-.02. Facility Services.

1. In order for the Alabama Medicaid Agency to reimburse the facility for ESWL treatment, the facility must have a signed ESWL Contract with the Agency.
2. For ESWL treatment to both kidneys during the same treatment period, Medicaid will pay the facility one-and-a-half times the regular reimbursement rate for this procedure.
3. Repeat ESWL treatments on the same recipient within a ninety-day period will be reimbursed at half the regular reimbursement rate for this procedure.
4. The ESWL reimbursement rate is an all-inclusive rate for each encounter and all services rendered in conjunction with the treatment (with the exception of the physician's and the anesthesiologist's) are included in the rate, such as lab, x-ray, and observation.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401 et seq. Rule effective October 13, 1987.

Rule No. 560-X-39-.03. Physician Services.

1. For ESWL treatment to both kidneys during the same treatment period, Medicaid will pay the surgeon one-and-a-half times the regular reimbursement rate for the surgical procedure.
2. For repeat ESWL treatments on the same recipient within a ninety-day period, Medicaid will reimburse the surgeon at half the regular reimbursement rate for the surgical procedure.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401 et seq. Rule effective October 13, 1987.

Rule No. 560-X-39-.04. Anesthesiologist Services.

Anesthesiologist services are not included in the facility's or physician's reimbursement rate and therefore can be billed separately.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401 et seq. Rule effective October 13, 1987.

Rule No. 560-X-39-.05 Participation.

1. In order to participate in the Title XIX Medicaid Program as an ESWL provider, the following requirements must be met:
   - (a) Submit written request for enrollment
   - (b) Submit documentation that the lithotripsy machine is FDA approved
   - (c) Provide documentation to indicate the lithotripsy machine is being operated under the authority of a valid Certificate of Need (CON). Documentation can be a copy of the valid CON or a copy of the contract between the provider of care and the holder of the CON.

Authority: State Plan Attachment 3.1-A, Page 1; Title XIX, Social Security Act; 42 C.F.R. Section 482.11, 482.12, 482.22, 482.54. Effective date of rule is December 14, 1990.

Chapter 40. Optional Targeted Case Management

Rule No. 560-X-40-.01. Definitions.

(1) Optional Targeted Case Management Services - those services to mentally ill adults (Target Group 1), mentally retarded adults (Target Group 2), handicapped children (Target Group 3), foster children (Target Group 4), pregnant women (Target Group 5), AIDS/HIV-positive individuals (Target Group 6), adult protective service individuals (Target Group 7), and individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults (Target Group 8), paid for by the Alabama Medicaid Agency to assist Medicaid-eligible persons in gaining access to needed medical, social, educational, and other services.

(2) Case Management Services Target Group 1 - Mentally Ill Adults - the population to be served consists of functionally limited individuals age 18 and over with multiple needs who have been found to require mental health case management. Such persons have a DSM-III-R diagnosis (other than mental retardation or substance abuse), impaired role functioning, and a documented need for access to the continuum of services offered through a Medicaid-enrolled mental health clinic services provider.

(3) Individual Case Managers for Mentally Ill Adults - professionals meeting the following qualifications:

(a) At a minimum, Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field, or

(b) A registered nurse, and

(c) Training in case management curriculum provided or approved by the Department of Mental Health and Mental Retardation and the Alabama Medicaid Agency.

(4) Case Management Providers for Mentally Ill Adults - Regional Boards incorporated under Act 310 of the 1967 Alabama Acts and Comprehensive Community Mental Health Centers. Providers must be certified by and provide services through a contract with the Alabama Department of Mental Health/Mental Retardation.

(5) Case Management Services Target Group 2 - Mentally Retarded Adults - the population to be served consists of individuals with a diagnosis of mental retardation who are 18 years of age or older. Diagnosis must be determined and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to mental retardation.

(6) Individual Case Managers for Mentally Retarded Adults - professionals meeting the following qualifications:

(a) At a minimum, Bachelor of Arts or Bachelor of Science degree, or

(b) A registered nurse, and

(c) Training in case management curriculum approved by the Alabama Medicaid Agency.

(7) Case Management Providers for Mentally Retarded Adults - Regional Boards incorporated under Act 310 of the 1967 Alabama Acts who have demonstrated ability to provide targeted case management services directly, or the Alabama Department of Mental Health and Mental Retardation. Providers must be certified by the Department of Mental Health and Mental Retardation.

(8) Case Management Services Target Group 3 - Handicapped Children - the population to be served consists of individuals age 0-21 considered to be handicapped as defined in the following six subgroups:

(a) Mentally retarded/related conditions: (Individuals in this subgroup will be age 0-17.)

1. Mentally retarded - diagnosis must be determined and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to mental retardation.

2. Related conditions - individuals who have a severe chronic disability that meets all of the following

(i) It is attributable to:

(I) Cerebral palsy or epilepsy; or

(II) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(ii) It is manifested before the person reaches age 22.

(iii) It is likely to continue indefinitely.

(iv) It results in substantial functional limitations in three or more of the following areas of major life activity.

(I) Self-care,

(II) Understanding and use of language,

(III) Learning,

(IV) Mobility,

(V) Self-direction,

(VI) Capacity for independent living.

(b) Seriously emotionally disturbed - In order to meet the definition of seriously emotionally disturbed, at least one criterion from Section 1. or 2. and two from Section 3. below must be met:

1. Mental Health Treatment History:

(i) Has undergone mental health treatment more intensive than outpatient care (emergency services, inpatient services, etc.);

(ii) Has experienced structured, supportive residential treatment, other than hospitalization, for a total of at least two months in their lifetime;

(iii) Has been assigned to a program of psychotropic medication; or

(iv) Has received mental health outpatient care for a period of at least six (6) months, or for more than twenty (20) sessions, or has been admitted for treatment on two or more occasions.

2. Indicators of Mental Health Treatment Needs:

(i) Family history of alcohol or drug abuse,

(ii) Family history of mental health treatment,

(iii) Failure to thrive in infancy or early development indicated in medical records,

(iv) Victim of child abuse, neglect or sexual abuse,

(v) Pervasive or extreme acts of aggression against self, others, or property (homicidal or suicidal gestures, fire setting, vandalism, theft, etc.), or

(vi) Runaway episode(s) of at least twenty-four (24) hours duration.

3. Current Functioning - problem areas of one year duration or substantial risk of over one year duration.

(i) Is not attending school (and has not graduated), is enrolled in a special education curriculum, or has poor grades;

(ii) Dysfunctional relationship with family and/or peers;

(iii) Requires help in basic, age-appropriate living skills;

(iv) Exhibits inappropriate social behavior; or

(v) Experiences serious discomfort from anxiety, depression, irrational fears, and concerns (indicated by serious eating or sleeping disorders, extreme sadness, social isolation, etc.).

(c) Sensory impaired:

1. Blind - One who after the best possible correction has no usable vision; therefore, must rely upon tactile and auditory senses to obtain information.

2. Partially sighted - One who has a visual acuity of 20/70 or less in the better eye with the best possible correction, has a peripheral field so restricted that it affects the child's ability to learn, or has a progressive loss of vision which may in the future affect the child's ability to learn.

3. Deaf - A hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification which adversely affects educational performance.

4. Blind multihandicapped - One who has a visual impairment (as defined in (c) 1. and (c) 2. above) and a concomitant handicapping condition.

5. Deaf multihandicapped - One who has a hearing impairment (as defined in (c) 3. above) and a concomitant handicapping condition.

6. Deaf-blind - One who has concomitant hearing and visual impairments, the combination of sensory impairments causing such severe communication and other developmental and educational problems that they cannot be properly accommodated in the educational programs by the Alabama School for the Blind or the Alabama School for the Deaf.

(d) Disabling health condition(s) - One which is severe, chronic and physical in nature, requiring extensive medical and habilitative/rehabilitative services:

1. Central nervous system dysraphic states, (such as spina bifida, hydranencephaly, encephalocele);
2. Cranio-facial anomalies, (such as cleft lip and palate, Apert's syndrome, Crouzon's syndrome);
3. Pulmonary conditions, (such as cystic fibrosis);
4. Neuro-muscular conditions, (such as cerebral palsy, arthrogryposis, juvenile rheumatoid arthritis);
5. Seizure disorders, (such as those poorly responsive to anticonvulsant therapy and those of mixed seizure type);
6. Hematologic/immunologic disorders, (such as hemophilia, sickle cell disease, aplastic anemia, agammaglobulinemia);
7. Heart conditions, (such as aortic coarctation, transposition of the great vessels);
8. Urologic conditions, (such as extrophy of bladder);
9. Gastrointestinal conditions, (such as Hirschsprung's Disease, omphalocele, gastroschisis);
10. Orthopedic problems, (such as clubfoot, scoliosis, fractures, poliomyelitis);
11. Metabolic disorders, (such as panhypopituitarism);
12. Neoplasms, (such as leukemia, retinoblastoma); and
13. Multisystem genetic disorders, (such as tuberosclerosis, neurofibromatosis).

(e) Developmentally delayed -

1. A child age birth to three years who is experiencing developmental delays equal to or greater than 25 percent as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:
   - (i) Cognitive development;
   - (ii) Physical development (including vision and hearing);
   - (iii) Language and speech development;
   - (iv) Psychosocial development; and
   - (v) Self-help skills.
2. One who has a diagnosed physical or mental condition which has a high probability of resulting in a development delay.

(f) Multihandicapped - An individual who has a combination of two or more handicapping conditions as described above. Each condition, if considered separately, might not be severe enough to warrant case management, but a combination of the conditions would be of such severity to adversely affect development.

(9) Individual Case Managers for Handicapped Children - Professionals meeting the following qualifications:

(a) At a minimum, a Bachelor of Arts or a Bachelor of Science degree, or

(b) A registered nurse, and

(c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(10) Case Management Providers for Handicapped Children - Providers must meet the following criteria:

(a) Demonstrated capacity to provide all core elements of case management:

1. assessment,
2. care/services plan development,
3. linking/coordination of services, and
4. reassessment/follow-up.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(c) Demonstrated experience with the target population.

(d) An administrative capacity to insure quality of services in accordance with state and federal requirements.

(e) A financial management system that provides documentation of services and costs.

(f) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(h) Demonstrated capacity to meet the case management service needs of the target population.

(11) Case Management Target Group 4 - Foster Children (Children in the Care, Custody or Control of the State or Receiving State Agency) - The population to be served consists of children age 0-21 who are receiving preventive, protective, family preservation or family reunification services from the State, or any of its agencies as a result of State intervention or upon application by the child's parent(s), custodian(s), or guardian(s); or children age 0-21 who are in the care, custody or control of the State of Alabama, or any of its agencies due to:

(a) The judicial or legally sanctioned determination that the child must be protected by the State as dependent, delinquent, or a child in need of supervision as those terms are defined by the Alabama Juvenile Code, Title 12, Chapter 15, Code of Alabama 1975; or

(b) The judicial determination or statutorily authorized action by the State to protect the child from actual or potential abuse under the Alabama Juvenile Code, Title 26, Chapter 14, Code of Alabama 1975, or other statute; or

(c) The voluntary placement agreement, voluntary boarding house agreement, or an agreement for foster care, between the State and the child's parent(s), custodian(s), or guardian.

(12) Individual Case Managers for Foster Children - Professionals meeting the following qualifications:

(a) At a minimum, a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services field, or

(b) A registered nurse, and

(c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(13) Case Management Providers for Foster Children - Providers must meet the following qualifications:

(a) Demonstrated capacity to provide all core elements of case management:

1. assessment,
2. care/services plan development,
3. linking/coordination of services, and
4. reassessment/follow-up.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(c) Demonstrated experience with the target population.

(d) An administrative capacity to insure quality of services in accordance with state and federal requirements.

(e) A financial management system that provides documentation of services and costs.

(f) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(h) Demonstrated capacity to meet the case management service needs of the target population.

(14) Case Management Target Group 5 - Pregnant Women - The population to be served consists of Medicaid-eligible women of any age in need of maternity services.

(15) Individual Case Managers for Pregnant Women - Professionals meeting the following qualifications:

(a) At a minimum, a Bachelor of Arts or a Bachelor of Science degree in social work from a school accredited by the Council on Social Work Education, or

(b) A registered nurse, and

(c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(16) Case Management Providers for Pregnant Women - Providers must meet the following qualifications:

(a) Demonstrated capacity to provide all core elements of case management:

1. assessment,
2. care/services plan development,
3. linking/coordination of services, and
4. reassessment/follow-up.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(c) Demonstrated experience with the target population.

(d) An administrative capacity to insure quality of services in accordance with state and federal requirements.

(e) A financial management system that provides documentation of services and costs.

(f) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(h) Demonstrated capacity to meet the case management service needs of the target population.

(17) Case Management Target Group 6 - AIDS/HIV-Positive Individuals - The population to be served consists of Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive as evidenced by laboratory findings.

(18) Individual Case Managers for AIDS/HIV-Positive Individuals - Professionals meeting the following qualifications:

(a) At a minimum, a Bachelor of Arts or a Bachelor of Science degree in social work from a school accredited by the Council on Social Work Education, or

(b) A registered nurse, and

(c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(19) Case Management Providers for AIDS/HIV-Positive Individuals - Providers must meet the following qualifications:

(a) Demonstrated capacity to provide all core elements of case management:

1. assessment,
2. care/services plan development,
3. linking/coordination of services, and

4. reassessment/follow-up.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(c) Demonstrated experience with the target population.

(d) An administrative capacity to insure quality of services in accordance with state and federal requirements.

(e) A financial management system that provides documentation of services and costs.

(f) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(h) Demonstrated capacity to meet the case management service needs of the target population.

(20) Case Management Target Group 7 - Adult Protective Service Individuals - The population to be served consists of individuals 18 years of age or older who are:

(a) At risk of abuse, neglect, or exploitation as defined in Section 38-9-2 Code of Alabama, 1975; or

(b) At risk of institutionalization due to his/her inability or his/her caretaker's inability to provide the minimum sufficient level of care in his/her own home.

(21) Individual Case Managers for Adult Protective Service Individuals - Professionals meeting the following qualifications:

(a) At a minimum, a Bachelor of Science degree, preferably in a human services field, or

(b) Eligible for state social work licensure or exempt from licensure, and

(c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(22) Case Management Providers for Adult Protective Service Individuals - Providers must meet the following qualifications:

(a) Demonstrated capacity to provide all core elements of case management:

1. assessment,
2. care/services plan development,
3. linking/coordination of services, and
4. reassessment/follow-up.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(c) Demonstrated experience of at least ten years with the target population in investigating abuse, neglect, and/or exploitation in domestic settings and follow-up services to victims of abuse, neglect, and/or exploitation.

(d) Authorized pursuant to Code of Alabama, 1975, Section 38-9-1 et seq to arrange for protective services for adults.

(e) An administrative capacity to insure quality of services in accordance with state and federal requirements.

(f) A financial management system that provides documentation of services and costs.

(g) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(h) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(i) Demonstrated capacity to meet the case management service needs of the target population.

(23) Case Management Services Target Group 8 – Individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults.

(24) Individual Case Managers for individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults – professionals meeting the following qualifications:

(a) At a minimum, Bachelor of Arts or Bachelor of Science degree, or
(b) A registered nurse, and
(c) Training in case management curriculum approved by the Alabama Medicaid Agency.

(25) Case Management Providers for individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults – Providers must meet the following criteria:

(a) Demonstrated capacity to provide all core elements of case management:
1. assessment,
2. care/services plan development,
3. linking/coordination of services, and
4. reassessment/follow up.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
(c) Demonstrated experience with the target population.
(d) An administrative capacity to insure quality of services in accordance with state and federal requirements.
(e) A financial management system that provides documentation of services and costs.
(f) Capacity to document and maintain individual case records in accordance with state and federal requirements.
(g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
(h) Demonstrated capacity to meet the case management service needs of the target population.

(26) Discriminatory Practices - Any practice prohibited by Title VI of the Civil Rights Act of 1964 (Federal law that prohibits discrimination in supplying services to recipients on the basis of race, color, creed, national origin, age, or sex) or Section 504 of the Rehabilitation Act of 1973 (the Federal law that prohibits discrimination in the supplying of services to recipients on the basis of a handicap). All providers must comply with these requirements to prevent discriminatory practices.

(27) Third Party - any individual, entity or program other than the recipient or his responsible party that is, or may be, liable to pay all or part of the cost of injury, disease, or disability of an applicant or recipient of Medicaid.

(28) Fiscal Agent - an agent under contract with Medicaid to receive and adjudicate Medicaid claims.

(29) Medicaid - The Alabama Medicaid Agency.

(30) DMH/MR - The Alabama Department of Mental Health and Mental Retardation.

(31) CMSP - Case management service provider.

(32) Noninstitutional Provider Agreement - the contract between a CMSP and Medicaid that specifies conditions of participation, funding arrangements, and operating mechanisms.

(33) Individual Plan of Care for All Target Groups - a document developed by the case manager listing the client's needs for service and assistance consistent with Rule No. 560-X-40-.03.

(34) Collateral - the case manager working with the Medicaid-eligible client, immediate family and/or guardians; Federal, State, or local service agencies (or agency representatives); and local businesses.

(35) Medicaid-eligible - persons eligible for Medicaid services under the Alabama State Plan as evidenced by a current, valid, Medicaid card.

(36) Regional 310 Boards - mental health/mental retardation boards established pursuant to Sections 22-55-1 through 22-51-14, Alabama Code, 1975 (Act 310,1967).

(37) Total Care Environments - ICF/MR facilities, ICF/MR 15-bed or less facilities, prisons, jails, nursing homes, and hospitals.

Author: Dittra Graham, Administrator, LTC Program Management Unit
Statutory Authority: Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193.
History: Rule effective July 12, 1988, November 10, 1988, April 17, 1990, June 1, 1990, October 13, 1990, September 12, 1991, December 12, 1991, October 13, 1992, January 13, 1993, June 14, 1994, May 11, 1998, and February 10, 1999. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Emergency Rule filed and effective February 22, 2003. **Amended:** Filed February 18, 2003; effective May 16, 2003. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Emergency Rule filed and effective January 30, 2004. **Amended:** Filed February 20, 2004; effective May 14, 2004.

Rule No. 560-X-40-.02. Eligibility.

(1) Providers of case management services must meet the following requirements:

(a) CMSP for the mentally ill must be certified by the Department of Mental Health and Mental Retardation as meeting the qualifications for enrollment as a case management provider under the provision of 560-X-40-.01 (6);

(b) CMSP for mentally retarded adults must meet the qualifications for enrollment as a case management provider under the provision of 560-X-40-.01(7);

(c) CMSP for handicapped children, foster children, pregnant women, and AIDS/HIV-positive individuals, adult protective service individuals, and individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults must meet the following criteria:

1. Demonstrated capacity to provide all core elements of case management:
   a. assessment,
   b. care/services plan development,
   c. linking/coordination of services, and
   d. reassessment/follow-up.
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. Administrative capacity to insure quality of services in accordance with state and federal requirements.
5. A financial management system that provides documentation of services and costs.
6. Capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

(d) Shall be in full compliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973;

(e) Shall be in full compliance with applicable Federal and State laws and regulations.

(2) Eligibility is limited to:

(a) Medicaid-eligible individuals age 18 and over who have a diagnosis of mental illness as established in Rule No. 560-X-40-.01.

(b) Medicaid-eligible individuals age 18 and over who have a diagnosis of mental retardation as established in Rule No. 560-X-40-.01.

(c) Medicaid-eligible individuals age 0-21 who are considered to be handicapped as established in Rule No. 560-X-40-.01.

(d) Medicaid-eligible individuals age 0-21 who are in the care, custody, or control of the State of Alabama as established in Rule No. 560-X-40-.01.

(e) Medicaid-eligible women of any age in need of maternity services as established in Rule No. 560-X-40.01.

(f) Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive as established in Rule 560-X-40-.01.

(g) Medicaid-eligible individuals age 18 and over who are at risk of abuse, neglect, or exploitation as established in Rule 560-X-40-.01.

(h) Medicaid-eligible persons who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults as outlined in the scope of service definition in the approved waiver document as established in Rule 560-X-40-.01.

(3) Persons applicable in one of the targeted groups may reside in their own home, the household of another, or in a supervised residential setting.

(4) No case management services will be provided to recipients in a hospital, skilled nursing facility, intermediate care facility, prison, jail, or other total care environment. However, in the HIV/AIDS and Related Illnesses Waiver, case management activities are available to assist recipients interested in transitioning from an institution into a community setting. Case management activities to facilitate the transition are limited to a maximum of 180 days. (See Chapter 107 of the Medicaid Provider Manual Section 107.5.4 for place of service codes.)

(5) Medicaid recipients receiving case management services through a waiver are not eligible for targeted case management.

(6) Targeted case management services for all target groups will be available in all areas of the state.

Author: Marilyn F. Chappelle, Director, Long Term Care Division
Statutory Authority: 42 CFR 435; Section 1915 (g), Social Security Act, Title XIX; State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193.
History: Rule effective July 12, 1988. Amended April l7, l990. Emergency change June 1, 1990. Amended October 13, 1990 and June 14, 1994. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Emergency Rule filed and effective February 22, 2003. **Amended:** Filed February 18, 2003; effective May 16, 2003. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Emergency Rule filed and effective January 30, 2004. **Amended:** Filed February 20, 2004; effective May 14, 2004. **Amended:** Filed August 20, 2007; effective November 16, 2007.

Rule No. 560-X-40-.03. Description of Covered Services, Limitations, and Exclusions. (General).

(1) Reimbursement is made only for services rendered pursuant to mentally ill adults, mentally retarded adults, handicapped children, foster children, pregnant women, AIDS/HIV-positive individuals, adult protective service individuals, and individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults as defined in Rule No. 560-X-40-.01. Case management services are those services which will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. The case manager shall accomplish these services through telephone contact with clients, face-to-face contact with clients, telephone contact with collaterals, and/or face-to-face contact with collaterals. The core elements of the service shall include the following:

(a) Needs assessment - a written comprehensive assessment of the person's assets, deficits, and needs. The following areas must be addressed when relevant:

1. Identifying information.
2. Socialization/recreational needs,
3. Training needs for community living,
4. Vocational needs,
5. Physical needs,
6. Medical care concerns,
7. Social/emotional status,
8. Housing, physical environment, and
9. Resource analysis and planning.

(b) Case planning - the development of a systematic, client-coordinated plan of care which lists the actions required to meet the identified needs of the client. The plan is developed through a collaborative process involving the recipient, his family or other support system, and the case manager.

(c) Service arrangement - through linkage and advocacy, the case management provider will interface the client with the appropriate person and/or agency through calling and/or visiting these persons or agencies on the client's behalf.

(d) Social Support - the case management service provider will, through interviews with the client and significant others, determine that the client possesses an adequate personal support system. If this personal support system is inadequate or nonexistent, the case management service provider will assist the client in expanding or establishing such a network through advocacy and linking the client with appropriate persons, support groups and/or agencies.

(e) Reassessment/Follow-up - the case management service provider will evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

(f) Monitoring - the case management provider ascertains on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

Author: Dittra Graham, Administrator, LTC Program Management Unit.
Statutory Authority: 42 C.F.R., 433; Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193.
History: Rule effective July 12, 1988. Amended April 17, 1990, September 12, 1991, December 12, 1991, October 13, 1992, January 13, 1993, and June 14, 1994. **Amended:** Filed December 18, 2000; effective March 12, 2001. **Amended:** Emergency Rule filed and effective February 22, 2003. **Amended:** Filed February 18, 2003; effective May 16, 2003. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Emergency Rule filed and effective January 30, 2004. **Amended:** Filed February 20, 2004; effective May 14, 2004.

Rule No. 560-X-40-.04. Payment Methodology for Covered Services.

(1) Governmental providers will be paid on a negotiated rate basis which will not exceed actual costs and which will meet all requirements of OMB Circular A-87. Nongovernmental providers will be reimbursed on a negotiated rate basis which will not exceed the upper limitations of 42 C.F.R. Section 447.325. The following documentation must be maintained in the recipient's record when billing for services:

(a) There must be a current comprehensive service plan which identifies the medical, nutritional, social, educational, transportation, housing and other service needs which have not been adequately accessed and a time frame to reassess service needs.

(b) Services must consist of at least one of the following activities:

1. Establishment of the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the recipient;

2. Assisting the recipient in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan;

3. Monitoring the recipient and service providers to determine that the services received are adequate in meeting the identified needs; or

4. Reassessment of the recipient to determine services needed to resolve any crisis situation resulting from changes in the family structure, living conditions, or other events.

(2) For target group 4 (Foster Children) and target group 7 (Adult Protective Service Individuals), reimbursement will be as follows:

(a) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Work Sampling Study. Rates will be adjusted annually based on the results of the previous four quarters. Random Moment Sampling may not be used as a method of documenting services provided to recipients. The Work Sampling Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation and identifies that at least one of the services listed above in (b) 1, 2, 3, or 4 has been provided.

(b) A maximum of one unit of case management services will be reimbursed per month for each eligible recipient receiving case management services. A unit of case management service is defined as at least one telephone or face to face contact for the purpose of providing at least one of the services listed above in (b) 1, 2, 3, or 4 with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be documented in the client's record and must be for the coordination or linkage of services for a specific identified recipient.

(3) Reimbursement for services provided by other governmental agencies will be based on actual costs as follows:

(a) Agencies will submit an annual cost report not later than sixty (60) days following the close of their fiscal year. This report will indicate not only the costs associated with providing the service but also statistical data indicating the units of service provided during the fiscal year.

(b) Cost reports will be reviewed for reasonableness and an average cost per unit of service will be computed.

(c) The average cost, trended for any expected inflation, will be used as the reimbursement rate for the succeeding year.

(d) If the cost report indicates any underpayment or overpayments for services during the reporting year, a lump sum adjustment will be made.

(e) New rates will be effective as of January 1 of each year.

(4) The Medicaid reimbursement for each service provided by a case management service provider shall not exceed the maximum allowable amount established by Medicaid as found in 42 C.F.R. Section 447.304.

(5) Actual reimbursement will be based on the rates in effect on the date of service.

Author: Dittra Skipper, Administrator, Project Development/Policy Unit, Long Term Care Division
Statutory Authority: 42 C.F.R., Section 447.325; OMB Circular A-87; Section 1915 (g); Social Security Act, State Plan for Medical Assistance Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193.
History: Rule effective July 12, 1988. Amended June 14, 1994 and October 12, 1995. Amended: Filed December 18, 2000; effective March 12, 2001.

Rule No. 560-X-40-.05. Third Party Liability.

The CMSP shall make all reasonable efforts to determine if there is a liable third party source, including Medicare, and in the case of a liable third party source, utilize that source for payments and benefits prior to filing a Medicaid claim. Third party payments received after billing Medicaid for service for a Medicaid recipient shall be refunded to the Alabama Medicaid Agency.

Authority: 42 C.F.R. Part 433; Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193. Rule effective July 12, 1988. Date of this amendment April 17, 1990.

Rule No. 560-X-40-.06. Payment Acceptance.

(1) Payment made by the Alabama Medicaid Program to a CMSP shall be considered payment in full for covered services rendered.

(2) No Medicaid recipient shall be billed for covered Medicaid services.

(3) No person or entity, except a potential third party source, shall be billed for covered Medicaid services.

Authority: 42 C.F.R. Section 447.15; Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193. Rule effective July 12, 1988.

Rule No. 560-X-40-.07. Confidentiality.

The CMSP shall not use or disclose, except to duly authorized representatives of Federal or State agencies, any information concerning an eligible recipient, except upon the written consent of the recipient, his attorney, or his guardian, or upon subpoena from a court of appropriate jurisdiction.

Authority: 42 C.F.R. Section 431.300, et. seq.; Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193. Rule effective July 12, 1988. This amendment is effective April 17, 1990.

Rule No. 560-X-40-.08. Records.

(1) The CMSP shall make available to the Alabama Medicaid Agency at no charge, all information describing services provided to eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of Federal and State agencies. Complete and accurate medical/psychiatric and fiscal records which fully disclose the extent of the service shall be maintained by the CMSP. Said records shall be retained for the period of time required by State and Federal laws.

(2) CMSP records must contain documentation of:
- (a) Name of recipient
- (b) Dates of services
- (c) Name of provider agency and person providing services
- (d) Nature, extent or units of services provided
- (e) Places of service.

Authority: 42 C.F.R. Part 433; Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193. Rule effective July 12, 1988.

Chapter 41. Psychiatric Facilities for Individuals Under Age 21

Rule No. 560-X-41-.01. General.

(1) Inpatient psychiatric services for recipients under age 21 are covered services when provided:

(a) Under the direction of a physician,

(b) By a psychiatric hospital enrolled as a Medicaid provider in accordance with Rule No. 560-X-41-.02; OR

(c) By a psychiatric residential treatment facility (RTF) which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children (COA), or by other accrediting organization with comparable standards that is recognized by the State;

(d) Before the recipient reaches age 21 or, if the recipient was receiving services immediately before he/she reached age 21, before the earlier of: (1) the date he/she no longer requires the services, (2) the date he/she reaches age 22, or (3) the expiration of covered days as limited in (2) below, and

(e) To a recipient who is admitted to and remains in the facility for the course of the hospitalization; and

(f) As certified in writing to be necessary in the setting in which it will be provided in accordance with 42 CFR 441.152.

(2) Inpatient psychiatric services for recipients under age 21 are unlimited if medically necessary and the admission and/or the continued stay reviews meet the approved psychiatric criteria. These days do not count against the recipient's inpatient day limitation for care provided in an acute care hospital.

(3) Residential psychiatric treatment services for recipients under age 21 are unlimited if medically necessary and the admission and continued stay reviews meet the approved psychiatric criteria. All treatment plan updates and certifications of need for services shall be performed as specified in Rule 560-X-41-.06.

(4) Referrals from a recipient's Patient 1st Primary Medical Provider (PMP) are not required for admissions to psychiatric hospitals or residential treatment facilities (RTFs).

(a) However, hospitals and RTFs should notify the recipient's PMP of the admission within 72 hours by faxing a copy of the recipient's face sheet to the PMP. Fax numbers for all PMPs may be found in the "About Medicaid" section on the Medicaid website, www.medicaid.state.al.us

(b) Ancillary services provided during the RTF stay may be billed fee-for-service if the recipient has been granted an exemption from the Patient 1st Program.

(c) Written requests for Patient 1st exemptions should be submitted to Medicaid by the recipient's case worker or the RTF at the time of admission to the residential facility.

(d) Requests must be submitted on the Patient 1st Medical Exemption Request found on the Medicaid website: medicaid.state.al.us under the Patient 1st tab. The block "Diagnosis/Other Information" should be checked and the statement "Recipient confined in RTF" entered in the appropriate space.

(e) Written notification shall be provided to Medicaid by the case worker or the RTF at the time of the recipient's discharge or transfer to another facility.

(f) All correspondence regarding Patient 1st should be mailed to:

Alabama Medicaid Agency
Attention: Patient 1st Program
P.O. Box 5624
Montgomery, AL 36103-5624

(5) Psychiatric hospitals and RTFs shall comply with all applicable regulations regarding the use of restraint and seclusion as cited in 42 CFR, Part 441, Subpart D, and 42 CFR, Part 483, Subpart G.

(6) The specific requirements for psychiatric medical records may be found at 42 CFR 482.61.

(7) The specific requirements for psychiatric facility staff may be found at 42 CFR 482.62.

Author: Lynn Sharp, Associate Director, Institutional Services.
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7 and 7.16; 42 CFR Part 441, Subpart D; Part 483, Subpart G; Section 440.240; 482.61; 482.62.
History: Rule effective October 1, 1988. Amended: November 1, 1988; February 9, 1989; September 13, 1989; August 21, 1991; and November 13, 1991. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-41-.02. Conditions of Participation.

(1) **Hospitals**: In order to participate in the Title XIX Medicaid program and to receive Medicaid payment for inpatient psychiatric services for individuals under age 21, a provider must meet the following conditions:

(a) Be certified for participation in the Medicare/Medicaid program;

(b) Be licensed as an Alabama psychiatric hospital in accordance with current rules contained in the Alabama Administrative Code Chapter 420-5-7. State hospitals which do not require licensing as per state law are exempt from this provision (Alabama Code, Section 22-50-1, et seq.);

(c) Be accredited by the Joint Commission on Accreditation of Healthcare Organizations;

(d) Have a distinct unit for children and adolescents;

(e) Have a separate treatment program for children and adolescents;

(f) Be in compliance with Title VI and VII of the Civil Rights Act of 1964 Section 504 of the Rehabilitation Act of 1973, and with the Age Discrimination Act of 1975.

(g) Execute an Alabama Medicaid Provider Agreement for participation in the Medicaid program;

(h) Submit a written description of an acceptable utilization review (UR) plan currently in effect; and

(i) Submit a budget of costs for medical inpatient services for its initial cost reporting period, if a new provider.

(2) Application by Alabama psychiatric hospitals for participation in the Medicaid program shall be made to the appropriate address indicated in the Provider Manual.

(3) Submission of a monthly inpatient census report using the PSY-4 form is required of enrolled psychiatric hospitals.

(a) The census report should list the names of all Medicaid children/adolescents who are admitted to and discharged from the hospital during the calendar month. This report should also list the names of the children and adolescents who remain in the hospital during the calendar month.

(b) This report must be received by Medicaid (all correspondence should be mailed to the appropriate address as indicated in the Provider Manual) on or before the tenth of each month for the preceding month.

(c) Failure to send the required reports within the specified time period will result in the hospital's reimbursement checks being withheld until the report is received.

(4) Residential Treatment Facilities (RTFs): In order to participate in the Title XIX Medicaid program and to receive payment for residential psychiatric treatment services for individuals under age 21, RTFs must meet the following conditions:

(a) Be accredited by JCAHO, CARF, COA, or be certified as an Alabama RTF in accordance with standards promulgated by the Alabama Department of Human Resources (DHR), the Department of Mental Health/Mental Retardation (DMH/MR) the Department of Youth Services (DYS),

or the Department of Children's Affairs (DCA). Upon enrollment and each time the RTF is recertified a copy of the certification letter must be sent to Medicaid within forty-five business days.

(b) Be in compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975;

(c) Execute a contract or placement agreement with DHR, DMH/MR, DYS, DCA, or Federally Recognized Indian tribes to provide residential psychiatric treatment services in the State of Alabama;

(d) Execute a provider agreement with Alabama Medicaid to participate in the Medicaid program;

(e) Submit a written description of an acceptable UR plan currently in effect;

(f) Submit a written attestation of compliance with the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences and the use of restraint and seclusion upon enrollment and yearly on or before July 21;

(g) Be in compliance with staffing and medical record requirements necessary to carry out a program of active treatment for individuals under age 21;

(5) All correspondence regarding application and certification by Alabama RTFs for participation in the Medicaid program should be mailed to the appropriate address indicated in the Provider Manual.

Author: Jerri Jackson, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D; and Section 431.107.
History: Rule effective October 1, 1988. Amended September 13, 1989; August 21, 1991; and November 13, 1991. **Amended:** Filed June 19, 2000; effective September 11, 2000. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended:** Filed: March 21, 2005; effective June 16, 2005. **Amended:** Filed: October 22, 2007; effective January 16, 2008.

Rule No. 560-X-41-.03. Inpatient Psychiatric Benefits.

(1) For purposes of this chapter, an inpatient is a person who has been admitted to a psychiatric facility for bed occupancy for purposes of receiving inpatient psychiatric services.

(2) The number of days of care charged to a recipient for inpatient psychiatric services is always units of full days. A day begins at midnight and ends 24 hours later. The midnight to midnight method is to be used in reporting days of care for the recipients, even if the facility uses a different definition of day for statistical or other purposes.

(3) Medicaid covers the day of admission, but not the day of discharge.

(4) Therapeutic visits away from the psychiatric hospital to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient.

(a) Payments for therapeutic visits away from the hospital are limited to no more than two visits with each visit not exceeding three days in duration per 60 calendar days per admission per recipient. The first calendar day begins with the day of admission.

(b) Therapeutic visits away from the hospital exceeding three days in duration are not covered and no part of these visits may be billed to Medicaid.

(c) Therapeutic visit records will be reviewed retrospectively by the PA Unit. Payments for therapeutic visits in excess of the amount as described in (4)(a) above will be recouped.

(d) This policy applies only to visits away from the psychiatric hospital. Therapeutic visits away from the RTF are not limited by this policy.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, 4.19-A. 42 C.F.R. Section 436.1004.

History: Rule effective October 1, 1988. Amended September 13, 1989; and January 14, 1992. **Amended:** Filed June 19, 2000; effective September 11, 2000. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-41-.04. Certification of Need for Inpatient Hospital Services.

(1) Certification of need for inpatient hospital services is a determination which is made by the certifying team as specified in (4) below regarding the Medicaid recipient's treatment needs for admission to the hospital.

(2) The appropriate team must certify that:

(a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;

(b) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(c) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

(3) The appropriate certifying team must complete the PSY-2 form which is the certification of need for inpatient hospital services.

(4) Certification of need for services must be made by teams specified as follows:

(a) For an individual who is a Medicaid recipient and is a non-emergency admission to the facility the certification of need for services must be made prior to the admission. If the certification is completed subsequent to admission, payment cannot be made for the period prior to the date the certification is completed. Certification must be made by an independent team that:

1. Includes a physician;
2. Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
3. Has knowledge of the individual's situation.

(b) Certification of need for services may be made by the team as specified in Rule No. 560-X-41-.04 (4)(a) provided the team is not:

1. Employed and reimbursed by the facility; or
2. In partnership with the attending physician; or
3. On the treatment team caring for the patient.

(c) For an individual who applies for Medicaid while in the facility, the certification of need for services must:

1. Be made by the team responsible for the plan of care as specified in Rule No. 560-X-41-.06(3); and
2. Cover any period before application for which claims are made.
3. If the certification is completed subsequent to the filing of the application, payment cannot be made for the period prior to the date the certification is completed.

(d) For emergency admissions the certification of need for services must be made by the team responsible for the plan of care as specified in Rule No. 560-X-41-.06(3) within 14 working days after admission.

(5) An emergency admission is described as a situation where the patient's condition is such that prompt provision of care is necessary to prevent the death or serious impairment of the health of the patient or others due to the individual's psychiatric condition. The presence of a court order does not in itself justify characterizing an admission as an emergency.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Section 441, Subpart D.
History: Rule effective October 1, 1988. Amended: September 13, 1989; August 21, 1991; November 13, 1991. Amended: Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.05. Medical, Psychiatric, and Social Evaluations.

(1) Before admission to a psychiatric facility or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each recipient's need for care in the facility and appropriate professional personnel must make a psychiatric and social evaluation. The psychiatric evaluation must be completed within 60 days of admission. The specific requirements for psychiatric medical records may be found at 42 CFR, 482.61.

(2) Each medical evaluation must include:
(a) Diagnosis (within the range of 290-316),
(b) Summary of present medical findings,
(c) Medical history,
(d) Mental and physical functional capacity,
(e) Prognosis, and
(f) A recommendation by a physician concerning:
1. Admission to the psychiatric facility, or
2. Continued care in the psychiatric facility for individuals who apply for Medicaid while in the facility.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Section 456.170, 482.61.
History: Rule effective October 1, 1988. Amended September 13, 1989; August 21, 1991; and November 13, 1991. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-41-.06. Active Treatment.

(1) Inpatient psychiatric services are covered by Medicaid only if they involve active treatment which means implementation of a professionally developed and supervised individual plan of care that is:
(a) Developed and implemented no later than 14 days after admission; and
(b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

(2) An individual plan of care is a written plan developed for each recipient in accordance with (2)(a-f) below to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan of care must:
(a) Be based on a diagnostic evaluation that includes examination of the medical, psychosocial, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;
(b) Be developed by a team of professionals specified in (3) below in consultation with the recipient and their parents, legal guardians, or others in whose care he/she will be released after discharge;
(c) State treatment objectives;
(d) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;
(e) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge; and

(f) Be reviewed at least every 30 days by the team specified in (3) below to determine that services provided are/were required on an inpatient basis, and recommend changes in the plan as indicated by the recipient's overall adjustment to the treatment.

(3) Team developing individual plan of care.

(a) The individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or who provide services to patients in, the facility. Based on education and experience, including competence in child psychiatry, the team must be capable of:

1. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
2. Assessing the potential resources of the recipient's family;
3. Setting treatment objectives; and
4. Prescribing therapeutic modalities to achieve the plan's objectives.

(b) The team must include, as a minimum, either:

1. A Board-eligible or Board-certified psychiatrist licensed in the State of Alabama;
2. A licensed clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State of Alabama.

(c) The team must also include one of the following:

1. A licensed social worker with specialized training or one year of experience in treating mentally ill individuals,
2. A registered nurse with specialized training or one year of experience in treating mentally ill individuals,
3. An licensed occupational therapist with specialized training, or one year of experience in treating mentally ill individuals, or
4. A psychologist who has a master's degree in clinical psychology or who has been certified by the State of Alabama.

(d) The specific staff requirements for psychiatric facilities may be found at 42 CFR 482.62.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D; 482.62
History: Rule effective October 1, 1988. Amended September 13, 1989; and November 13, 1991.
Amended: Filed September 21, 2001; effective December 14, 2001. **Amended**: Filed March 21, 2005; effective June 16, 2005

Rule No. 560-X-41-.07. Utilization Review (UR) Plan.

As a condition of participation in the Title XIX Medicaid program, each psychiatric facility shall:

(1) Have in effect a written UR plan that provides for review of each recipient's need for services that the facility furnishes to him. This written UR plan must meet the requirements under 42 C.F.R. Section 456.201 through 42 C.F.R. Section 456.245;

(2) Maintain recipient information required for UR under 42 C.F.R. Section 456.211, which shall include the certification of need for service and the plan of care; and

(3) Provide a copy of the UR plan and any subsequent revisions to Medicaid for review and approval.

Authority: 42 C.F.R. Section 456.200 through 42 C.F.R. Section 456.245. Rule effective October 1, 1988. Effective date of this amendment September 13, 1989.

Rule No. 560-X-41-.08. Payment.

(1) Payment for inpatient services provided by psychiatric hospitals shall be the per diem rate established by Medicaid for the hospital which is based on the Medicaid cost report and provisions of Chapter 23 of the Alabama Medicaid Administrative Code.

(2) Providers are required to file a complete uniform Medicaid cost report for each fiscal year. One copy of this report must be received by Medicaid within three months after the Medicaid cost report year-end.

(3) Hospitals that terminate participation in the Medicaid program must provide a final cost report within 120 days of the date of termination of participation.

(4) If a complete uniform cost report is not filed by the due date, the hospital -shall be charged a penalty of $100.00 per day for each calendar day after the due date.

(5) Medicaid pays for residential treatment services provided by RTFs according to the per diem rate established in the placement agreement between the RTF and the contracting state agency (DHR, DYS, DMH, DCA).

(6) Providers should not send recipients bills or statements for covered services once that recipient has been accepted as a Medicaid patient. Providers may send a notice to the recipient stating their claim is still outstanding if the notice indicates in bold print, **"THIS IS NOT A BILL."** Providers are responsible for follow-up with the fiscal agent or Medicaid on any billing problems or unpaid claims. Providers may not bill the recipient for the difference between charges billed and the amount paid by Medicaid. Providers agree to accept the amount paid by Medicaid as payment in full. Providers may bill recipients only for the allowable copay amount, for services not covered by Medicaid, or when benefits have been exhausted.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 4.19-A, 42 CFR, Section 413.
History: Rule effective October 1, 1988. Amended: November 1, 1988; February 9, 1989; and September 13, 1989. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended:** Filed: March 21, 2005; effective June 16, 2005

Rule No. 560-X-41-.09. Inpatient Review Criteria.

(1) All patients seeking admission to a psychiatric hospital must require psychiatric services that can only be provided on an inpatient basis. These psychiatric services must involve implementation of a professionally developed and supervised individualized plan of care.

(2) The inpatient admission criteria utilized by Medicaid require a documented need for inpatient psychiatric services. A patient seeking admission to a psychiatric hospital must meet at least one of the following criteria:

(a) Inappropriate performance of activities of daily living as evidenced by:
1. inappropriate hygiene or grooming;
2. psychomotor agitation or retardation;
3. severe disturbances in appetite or sleep.

(b) Impaired safety as evidenced by:
1. inappropriate, depressed, agitated mood;
2. suicidal ideation, threat, gesture, or attempt;
3. substance abuse;
4. inappropriate behavior requiring intervention;
5. noncompliance with medication or treatment regimen.

(c) Impaired thought process as evidenced by:

1. verbal or behavioral disorganization;
2. thought disorganization, hallucinations, paranoid ideation, phobias, etc.;
3. impaired reality testing;
4. bizarre or delusional behavior;
5. disorientation or memory impairment to the degree of endangering patient's welfare;
6. severe withdrawal or catatonia.

(e) Inpatient treatment required due to:

1. failure of outpatient therapy;
2. failure of social or family functioning which places patient at increased risk;
3. treatment in a less restrictive environment not feasible due to patient's behavior;
4. need for intensive inpatient evaluation;
5. need for 24-hour skilled and intensive observation;
6. need for evaluation of drug tolerance;
7. recurrence of psychosis not responding to outpatient treatment;
8. toxic effects from therapeutic psychotropic drugs;
9. blood or urine positive for barbiturates, narcotics, alcohol, or other toxic agents in a patient displaying physical symptoms.

(3) All patients receiving inpatient psychiatric services must be involved with active treatment. "Active treatment" is defined as implementation of a professionally developed and supervised individualized plan of care. At least one professional member of the interdisciplinary treatment team must be involved in providing active intervention for an unresolved or active problem as noted on the plan of care. Appropriate members of the treatment team must document active intervention when a patient's placement options are unresolved.

(4) The continued stay criteria utilized by Medicaid require a documented need for continuation of inpatient psychiatric services. A patient seeking continued stay in a psychiatric hospital must meet at least one of the following criteria:

(a) Active intervention by at least one member of the interdisciplinary treatment team for an unresolved problem on the patient's treatment plan;
(b) Medication changes, administration of PRN medications, medications in liquid form (for suspected noncompliance);
(c) Episodes of inappropriate behavior requiring intervention;
(d) Noncompliance with treatment regimen;
(e) Suicidal ideation, threat, gesture, or attempt;
(f) No availability of placement options appropriate to patient's needs.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachments 3.1-A, p. 7.16 and 4.19-B, p. 8; 42 CFR, Part 441, Subpart D.
History: Rule effective September 13, 1989. Amended September 11, 2000. Amended: Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.10. Authorization for Inpatient Treatment Services.

(1) All admissions to psychiatric hospitals for recipients under the age of 21 must be approved by Medicaid prior to payment.

(2) For an individual who is a Medicaid recipient at the time of admission, the attending physician must sign a Psychiatric Admission form indicating the medical necessity of the admission.

(3) For an individual who applies for Medicaid while in the facility, the Psychiatric Admission form must be signed by the attending physician at the time application for Medicaid is made.

(4) Providers of care are responsible for submitting a completed Psychiatric Admission form to the PA Unit at Medicaid. The following information shall be included on the Psychiatric Admission form:

(a) Events leading to present hospitalization
(b) Diagnosis (within the range of 290-316)
(c) History and physical
(d) Mental and physical capacity
(e) Summary of present medical findings including prognosis
(f) Plan of care.

(5) This information will be reviewed by the PA Unit utilizing the Medicaid psychiatric criteria as described in Rule 560-X-41-.09 to determine approval or denial of the admission. This information must be received by the PA Unit at Medicaid within eight working days of the recipient's admission to the facility.

(6) Admission information not received by the PA Unit within the eight working days will be approved effective on the day the information is received, provided admission criteria are met.

(7) The PA Unit will review the submitted admission information to determine whether the admission is approved or denied. The PA unit will notify the provider of the approval or denial via telephone or fax. A 10 digit prior approval number issued by the PA Unit will be required on claims submitted for payment.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Section 456.170-.171.
History: Rule effective September 13, 1989. Amended August 21, 1991; November 13, 1991; June 14, 1994; September 11, 2000. Amended: Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.11 Inpatient Continued Stay Reviews.

(1) The provider’s interdisciplinary treatment team is responsible for performing continued stay reviews on recipients who require continued inpatient hospitalization.

(2) Continued stay updates must include:

(a) Master Treatment Plan and subsequent changes;
(b) Utilization review worksheet;
(c) Physician's progress notes, nursing progress notes and, if requested, social worker's progress notes (individual and family sessions, discharge planning). The PA Unit may request this information when documentation included in (a) and (b) is insufficient to justify the continued hospital stay.

(3) Continued stay updates will be reviewed by the PA Unit and the next continued stay review date assigned upon approval of the continued hospitalization. Continued stay updates not received by the

next review date will be approved on the date the information is received by the PA Unit provided the review criteria are met. These stays must be split billed to separate the authorized days from the non-authorized days.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Section 456.233-.234,
History: Rule effective August 21, 1991. Amended November 13, 1991; September 11, 2000. Amended: Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.12 Recertification of Need for Inpatient Care.

(1) Recertification of need for inpatient care must be made on the PSY-3 form at least every 60 days after admission by the patient's attending physician and filed in the patient's medical record.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 456.160.
History: Rule effective August 21, 1991. Amended November 13, 1991. Amended: Filed June 19, 2000, effective September 18, 2000.

Rule No. 560-X-41-.13 Certification of Need for Residential Treatment Services.

(1) Recipients seeking admission to a residential treatment facility (RTF) shall require continuous and active psychiatric treatment and care in a facility which meets the standards in 560-X-41-.02 (4)(a-g).

(2) Recipients seeking admission to a RTF must meet at least one of the admission criteria listed in 560-X-41-.09 (2)(a-d).

(3) For elective or non-emergency admissions of individuals who are Medicaid-eligible when admitted to the RTF, a certification of the need for services shall be performed by an independent team that:

(a) Includes a physician;
(b) Has competence in diagnosis and treatment of mental illness (preferably in child psychiatry); and
(c) Has knowledge of the individual's situation.

5. The independent team shall certify that:

(a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient; and
(b) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
(c) Services can reasonably be expected to improve the recipient's condition or prevent further regression so that inpatient services will no longer be needed.

6. The independent team shall complete and sign a Certification of Need for Services: Non-Emergency Admission form (# 370) not more than 30 days prior to admission. This form shall be filed in the recipient's medical record to verify compliance with this requirement. This form may be downloaded from the "Forms" section on the Medicaid website www.medicaid.state.al.us

(6) For emergency admissions or for individuals who become eligible for Medicaid after admission , a certification of need for services shall be performed by an interdisciplinary team. The team responsible for the plan of care must include either:

(a) A board-eligible or board-certified psychiatrist licensed in the State of Alabama; or
(b) A licensed clinical psychologist and a physician; or
(c) A physician licensed in the State of Alabama with specialized training and experience in diagnosis and treatment of mental illness and a psychologist with a master's degree in clinical psychology; and one of the following:
1. Licensed social worker with specialized training or one year of experience in treating the mentally ill; or
2. RN with specialized training or one year of experience in treating the mentally ill; or
3. Licensed occupational therapist who has specialized training or one year of experience in treating the mentally ill; or
4. Psychologist with a master's degree in clinical psychology.

(7) The interdisciplinary team shall perform the same certification of need for services as listed for elective and non-emergency admissions in (4)(a-c) above. The team shall complete and sign a Certification of Need for Services: Emergency Admission form (#371), within 14 days of the emergency admission. This form shall be filed in the recipient's medical record to verify compliance with this requirement. This form may be downloaded from the "Forms" section on the Medicaid website www.medicaid.state. al.us.

(8) For individuals who become eligible for Medicaid after their admission to the facility, this form shall be completed on or before the date of the application for Medicaid coverage and shall include all days for which Medicaid payment will be requested.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D
History: New Rule Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.14 Residential Continued Stay Reviews.

(1) The RTF's interdisciplinary team shall be responsible for performing continued stay reviews on recipients who require continuous residential services.

(2) Recipients requiring continued stays in RTFs must meet at least one of the criteria listed in 560-X-41-.09(4)(a-f).

(3) The plan of care shall be reviewed at least every 30 days by the interdisciplinary team to:
(a) Determine that services are/were medically necessary; and
(b) Recommend changes in the plan as indicated by the recipient's overall adjustment to treatment.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D
History: New Rule Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.15 Recertification of Need for Residential Services.

Recertification of need for residential services shall be noted on the recipient's plan of care by the attending physician at least every 30 days.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D
History: New Rule Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.16 Reporting of Deaths and Serious Occurrences.

(1) RTFs seeking enrollment with Medicaid must meet the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences.

(2) RTFs shall submit a written attestation of compliance with the federal rules at the time of enrollment. The written attestation must be signed by an individual who has the legal authority to obligate the facility.

(3) At a minimum, the attestation shall include:

(a) The name, address, telephone number of the facility, and provider number (if applicable);

(b) The signature and title of the individual who has the legal authority to obligate the facility;

(c) The date the attestation is signed;

(d) A statement certifying that the facility currently meets all of the requirements of 42 CFR, Part 483, Subpart G, governing the use of restraint and seclusion;

(e) A statement acknowledging the right of the State Survey Agency (or its agents) and, if necessary, the Centers for Medicare and Medicaid Services (CMS), to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences;

(f) A statement that the facility will notify Medicaid if it no longer complies with the requirements of the rule; and

(g) A statement that the facility will submit a new attestation of compliance in the event the individual who has the legal authority to obligate the facility is no longer in such position.

(4) RTFs may use the RTF Attestation Letter to fulfill this requirement. This form may be downloaded from the "Forms"section on the Medicaid website www.medicaid.state.al.us. The information in the form letter should be submitted to Medicaid on the facility's letterhead.

(5) Participating RTFs shall be required to report a resident's death, serious injury, or suicide attempt to Medicaid and the state-designated Protection and Advocacy system. In addition to the reporting requirements to Medicaid, RTFs shall report the death of any resident to the CMS Regional Office in Atlanta, Georgia. These reports shall be filed with the agencies noted above no later than the close of business the next business day after the occurrence.

(6) RTFs shall report to the CMS Regional Office the death of any resident no later than the close of business the next business day after the resident's death. This report shall include:

(a) Name of the deceased resident;

(b) Description of the occurrence;

(c) Name, address, telephone number of the RTF; and

(d) Any other information the RTF is able to provide regarding the death.

(7) RTFs shall document in the resident's medical record that the death was reported to the CMS Regional Office.

(8) RTFs shall document in the resident's medical record that any serious occurrence, such as death, serious injury, or suicide attempt, was reported to Medicaid and the state-designated Protection and Advocacy system.

(9) Medicaid shall validate the attestations for a random sample of 20 percent of participating RTFs on an annual basis. The selected sample will be transmitted to the State Survey Agency in order to conduct on-site surveys to ensure the facilities have policies and procedures in place consistent with the attestation and are complying with the requirements of 42 CFR, Part 483, Subpart G.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 483, Subpart G
History: New Rule Filed September 21, 2001; effective December 14, 2001

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Chapter 42. ICF/MR Reimbursement

Rule No. 560-X-42-.01. ICF/MR Reimbursement – Preface.

This Regulation states the Medicaid policy regarding ICF/MR reimbursement and establishes the accepted procedures whereby reimbursement is made to these providers. Because of the length and complexity of this Chapter, it has been divided into sections to facilitate its utilization.

Authority: Code of Alabama, 41-22-2. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.02. Introduction.

1. This Chapter of the Alabama Medicaid Regulations has been promulgated by the Alabama Medicaid Agency (Medicaid) for the guidance of providers of Medicaid ICF/MR care. This Chapter is applicable to those providers classified as ICF/MR.
2. The Alabama Medicaid Program is administered by Medicaid under the direction of the Governor's Office. Reimbursement principles for ICF/MR providers are outlined in the following sections of this Chapter. These principles, hereinafter referred to as "Medicaid Reimbursement Principles," are a combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and principles and procedures promulgated by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated ICF/MRs. These principles are not intended to be all inclusive, and additions, deletions, and changes to them will be made by Medicaid, as required. Providers are urged to familiarize themselves fully with the following information, as cost reports must be submitted to Medicaid in compliance with this regulation.
3. If this Regulation is silent on a given point, Medicaid will normally rely on Medicare (Title XVIII) Principles of Retrospective Reimbursement and, in the event such Medicare Principles provide no guidance, Medicaid may impose other reasonability tests. The tests include, but are not limited to, such tests as:
   (a) Does the cost as reported comply with generally accepted accounting principles?
   (b) Is the cost reasonable on its own merit?
   (c) How does the cost compare with that submitted by similarly sized homes furnishing like levels of care?
   (d) Is the cost related to resident care and necessary to the operations of an ICF/MR facility?
4. It is recognized that there are many factors involved in operating an ICF/MR facility. The size of the home, the levels of care offered, the intensity of care required, the geographical location (rural or urban), the available labor market, and the availability of qualified consultants are only examples of such factors, and considerable effort has been made to recognize such variables during the development of this Chapter. Only reported costs reflecting such variables without exceeding the "prudent buyer" concept or other applied tests of reasonability will be allowed by Medicaid. Medicaid will consider granting variances from the Medicaid Reimbursement Principles whenever a provider submits convincing evidence that it can provide a service in a more cost effective manner if such variance is permitted.
5. Records must be kept by the provider which document and justify costs, and only those costs which can be fully and properly substantiated will be allowed by Medicaid. Increases over amounts reported on a provider's previous cost reports, except those increases inherent in normal inflation, will be closely examined for reasonableness.

6. The principles presented herein are based on the "prudent buyer" concept. An ICF/MR administrator is expected to conduct his business in an efficient and conservative manner, and to submit requests for reimbursement only for costs which are absolutely necessary to the conduct of an economically and efficiently operated ICF/MR facility.
7. Unallowable costs which are identified during either desk audits or field audits will be disallowed despite similar costs having been included in prior cost reports without having been disallowed.
8. The only source of the funds expended by Medicaid is public funds, exacted from the taxpayers through state and federal taxes. Improper encroachment on these funds is an affront to the taxpayers and will be treated accordingly.
9. To assure only necessary expenditures of public money, it will be the policy of Medicaid to:
   (a) Conduct on-site audits of facilities on an unannounced basis, although prior announcement may be made at the discretion of Medicaid.
   (b) Determine audit exceptions in accordance with Medicaid Reimbursement Principles.
   (c) Allow only non-extravagant, reasonable, necessary and other allowable costs and demand prompt repayment of any unallowable amounts to Medicaid.
10. In the event desk audits or field audits by Medicaid's staff reveal that providers persist in including unallowable costs in their cost reports, Medicaid may refer its findings to the Medicaid Program Integrity Division, Medicaid Counsel, and/or the Alabama Attorney General.
11. CAUTION: The cost allowances contained in this Chapter are maximum allowances, and are not considered a standard. Providers whose costs are normally and historically below the presented amounts may not automatically report the larger amount.
12. While the responsibility for establishing policies throughout the Medicaid Program rests with Medicaid, comments on the contents of this Chapter are invited and will be given full consideration.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250 -.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.03. Definitions.

1. Accrual Method of Accounting - Revenues must be allocated to the accounting period in which they are earned and expenses must be charged to the period in which they are incurred. This must be done regardless of when cash is received or disbursed.
2. Cash Basis of Accounting - Revenues and expenditures are recognized when cash is received and disbursed.
3. Adjusted Reported Costs - The net reported costs from Schedule B, Column 3, of the cost report adjusted, as required, for unallowable costs, and cost recovery items.
4. Medicaid - The Alabama Medicaid Agency.
5. Medicaid Reimbursement Principles - A combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and procedures and principles promulgated by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated ICF/MR facility.
6. Allowable Costs - The costs of a provider of ICF/MR services which must be incurred by an efficiently and economically operated facility and which are not otherwise disallowed by the reimbursement principles established under and incorporated into this Chapter.
7. Approved Bed Rate - The Medicaid rate paid to facilities for approved beds. (See Section 4 for computation.)
8. Chapter - This Chapter of the Alabama Medicaid Agency Administrative Code.
9. Class - Grouping formed according to type of facility. Medicaid classes to which this Chapter applies are: (1) Institutionally based, larger than 15 beds, (2) Institutionally based with at least four (4) but no more than fifteen (15) beds.

10. Cost Recovery Item - Income generated by an element of allowable cost.
11. Facility - Any structure licensed by the State of Alabama for the purpose of providing long-term care to the aged, ill, or disabled.
12. Fair Market Value - The bona fide price at which an asset would change hands or at which services would be purchased between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having reasonable knowledge of the relevant facts.
13. Fiscal Year - The 12 month period upon which providers are required to report their costs, being the period from October 1st through September 30th, also called the "reporting period."
14. HCFA - The Health Care Financing Administration, an agency of the U.S. Department of Health and Human Services.
15. HIM-15 - The (publication) title of the Medicare Provider Reimbursement Manual, a publication of HCFA. All references to this manual or to Title XVIII Principles of Reimbursement in Chapter 42 are for the "Retrospective" Reasonable Cost Reimbursement Principles and not those of the 10-1-83 Prospective Medicare System.
16. Hold Bed Days - The period during which a provider receives payment from a source other than Medicaid for the reservation of a bed in a long term care facility for a particular resident who is not in the facility. Hold bed days do not include therapeutic leave covered by Medicaid.
17. Home Office Costs - See Rule No. 560-X-42-.17 for in-depth discussion and treatment of home office costs.
18. Imprest System - A system in which any fund is replenished by writing a check equal to the payments which have been made out of the fund. Examples of such funds are petty cash and payroll.
19. Interest - Cost incurred for the use of borrowed funds.
    (a) Necessary Interest - Incurred to satisfy a financial need of the provider on a loan made for a purpose directly related to resident care. Necessary interest cannot include loans resulting in excess funds or investments.
    (b) Proper Interest - Must be necessary as described above, incurred at a rate not in excess of what a prudent borrower would have to pay in the money market at the time the loan was made, and incurred in connection with a loan directly related to resident care or safety.
20. Interim Per Diem Rate - A rate intended to approximate the provider's actual or allowable costs of services furnished until such time as actual allowable costs are determined.
21. Intermediate Care Facility for the Mentally Retarded (ICF/MR) - That type of facility which fully meets all requirements for licensure under State law to provide on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities. The primary purpose of such institutions is to provide health and/or rehabilitative services for mentally retarded individuals.
22. Medicaid Occupancy - The percent of the total residents in an ICF/MR facility who have been certified eligible for Medicaid benefits.
23. Medicaid Per Diem Rate - The amount paid by Medicaid for ICF/MR services provided to Medicaid residents for a one-day period.
24. Necessary Function - A function being performed by an employee which, if that employee were not performing it, another would have to be employed to do so, and which is directly related to providing ICF/MR services.
25. Proprietary Provider - Provider, whether a sole proprietorship, partnership, or corporation, organized and operated with the expectation of earning profit for the owners as distinguished from providers organized and operated on a non-profit basis.
26. Provider - A person, organization, or facility who or which furnishes services to residents eligible for Medicaid benefits.

27. Prudent Buyer Concept - The principle of purchasing supplies and services at a cost which is as low as possible without sacrificing quality of goods or services received.
28. Related - The issue of whether the provider and another party are "related" will be determined under the HIM-15 rules defining "related parties."
29. Reasonable Compensation - Compensation of officers and/or employees performing a necessary function in a facility in an amount which would ordinarily be paid for comparable services by a comparable facility.
30. Reasonable Costs - Necessary and ordinary cost related to resident care which a prudent and cost-conscious businessman would pay for a given item or service.
31. Resident Day - Any day that a bed is either occupied or is not available for immediate occupancy by a newly admitted resident, but only if some payment and/or promise of payment is received either at the full per diem or a reduced rate.
32. 90th Percentile - The cost ceilings applied to the cost per resident day for Medicaid reimbursement is derived as follows:
    (a) The ICF/MRs are divided into their respective classes and are listed in ascending order based on their respective cost per resident day.
    (b) The number of homes in each class is multiplied by 90% to determine the position of the ICF/MR facility that represents the 90th percentile. Thus, 90% of the homes in each class will have costs per resident that are equal to or less than that of the 90th percentile home. Likewise, the remaining homes will have costs per resident day in excess of the costs of the 90th percentile home.
33. State Plan - The State Plan promulgated by the State of Alabama under Title XIX of the Social Security Act, Medical Assistance Program.
34. Straight Line Method of Depreciation - Depreciation charges spread equally over the estimated life of the asset so that at the expiration of that period the total cost that was determined to be recoverable through such charges has been recovered.
35. Unallowable Costs - All costs incurred by a provider which are not allowable under the Medicaid Reimbursement Principles.
36. Use Allowance - In lieu of depreciation, state owned and operated facilities may claim a use allowance. The annual use allowance for building and improvements shall be two percent of acquisition cost. The annual use allowance for major movable equipment shall be six and two-thirds percent of acquisition cost.
37. Unapproved Bed Rate - The Medicaid rate paid to ICF/MR facilities for unapproved beds (See Rule No. 560-X-42-.04 for computation.)
38. Net Lease - A lease in which the tenant pays all or a substantial part of the cost of maintaining and operating the facility; (e.g., maintenance costs, insurance, and real estate taxes).

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250 - .255, et seq. Rule effective October 13, 1988. Effective date of this amendment September 13, 1989. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.04. Medicaid Per Diem Rate Computation Methodology.

1. All ICF/MR providers will be grouped into two (2) functional categories:
   - (a) ICF/MRs larger than 15 beds.
   - (b) ICF/MRs (15 beds or less).
2. Within each grouping, the following methodology shall apply: cost reports, as submitted, will be desk audited for any unallowable costs, and those costs will be removed from the subsequent computations. The providers' reported allowable costs will be used as the basis for calculating new per diem rates. The following methodology will be used for determining the per diem rates for approved beds.
   - (a) Net reported costs (Schedule B, Column 5 of the cost report) shall be adjusted for cost recovery items, unallowable cost and excess administrative costs.
   - (b) Costs as adjusted in (a) above (less any property cost) shall be separated into Salaries and Other cost. The Other cost will be multiplied by the Medicaid inflation index to calculate a budgeted increase in other expense. To determine a projected increase in salaries, the amount or % increase specified by the provider shall be used.
   - (c) Budgeted increases/decreases (rent, depreciation, interest, major repairs) shall be calculated using as a basis data supplied by the provider.
   - (d) In lieu of depreciation, a use allowance shall be determined for buildings and improvements for State owned and operated facilities.
   - (e) The allowable equity capital will be multiplied by the percentage rate of return specified in Rule No. 560-X-42-.13 and the product will be the allowance for Return on Equity Capital. (This allowance applies to proprietary providers only.)
   - (f) The sum of the amounts as determined in (a) - (e) above shall be divided by total resident days as reported by the provider. The resulting average cost per day will be arrayed within each of the two functional groupings of facilities. The number of facilities in each grouping will be multiplied by 90% to determine the position of the facility that represents the 90th percentile. If the 90th percentile does not fall on a whole number, the Agency will round up or down to the nearest whole number. If the number falls on a .0 to .49, we will round down. If the number falls on .50 or higher, we will round up. Counting from the bottom of the array (upward) that facility's cost in each grouping will be the ceiling reimbursement rate for all costs of the homes within that functional class.

Example:

1. Net Reported Costs (Schedule B, Column 5)
2. Deduct: Cost recovery items, unallowable cost, excess administrative compensation.
   - i. a. Separate Cost (less property cost) into salary and other cost.
   - ii. Calculate the budgeted increase for salaries, add to salaries.
   - iii. Multiply other cost by the Medicaid inflation index, add to other cost.
   - iv. Add: Any budgeted increases/decreases (Rent, depreciation, interest, major repairs, add back property cost (if applicable) that was deducted in (a) above.
   - v. In lieu of depreciation, a use allowance for buildings and improvements shall be determined for State owned and operated facilities and added to cost as adjusted in (a) - (d) above.
   - vi. Add allowance for return on equity (if applicable).
   - vii. Total items (b) - (f) above. Divide this sum by total resident days as reported by the provider.
   - viii. Determination of 90th percentile ceiling rate based on array of amounts in Item g for all providers within the grouping.

3. Computation of a per diem rate for unapproved beds will follow the methodology as set out in sections 1 - 2 above, except that no return on equity capital will be allowed with respect to such unapproved beds. Also, there will be no depreciation, use allowance, interest, taxes or other such costs allocable to unapproved beds.
4. Ceilings Not Subject to Adjustments. Once the percentile ceilings have been established for a fiscal year, they will be final and not normally subject to revision or adjustment during that year. Since the ceiling rates are based on information provided in the cost reports, it is to the benefit of each provider to insure that the provider's information is correct and accurate. If obvious errors are detected during the desk audit process, providers will be given an opportunity to submit corrected data.
5. After the rates have been set, each provider will be notified of its rate. If the provider has questions regarding any disallowances made during the rate setting process, they may request further information in writing. Only those requests submitted in writing will be honored.
6. The monthly rate is computed by multiplying the per diem rate by 30.42 days. This rate is valid for residents in the facility for a full month. For partial month coverage, the per diem rate is multiplied times the number of days.
7. Dollar values are rounded.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250 - .255. Rule effective October 13, 1988 and amended December 12, 1988. Emergency rule effective July 1, 1989, and amended September 13, 1989 and July 13, 1993; and March 15, 1994. This amendment is effective March 14, 1996.

Rule No. 560-X-42-.05. Medicaid Inflation Index.

1. The Medicaid Inflation Index will be used in lieu of budgeting to adjust certain actual allowable costs from the reporting period for the purpose of computing the prospective per diem rate payable and for such other adjustments as may be specified in this Chapter.
2. The Medicaid Inflation Index shall be based upon the economic indicators as published by Data Resources, Inc. (DRI) for the Department of Health and Human Services. The indicators shall be the Market Basket Index of Operating Costs - Skilled Nursing Facility, which are published quarterly, whereas the Medicaid fiscal year for cost reporting and rate setting purposes ends on September 30th. Therefore, the Medicaid Inflation Index for a rate period will be the DRI Index for the twelve-month period ending on the calendar quarter for which the index has been published or made available at October 1st of each year.
3. The Medicaid Inflation Index will be established each October 1st for the current fiscal year based upon the information then available to Medicaid and will not be adjusted again until the next following October 1st, regardless of any later release of revised or additional information relevant to the determination of the index.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.06. Resident Days.

1. A resident day is incurred when any one of the following conditions have been met:
   (a) Care is rendered to a resident in the facility. This results when a resident is rendered services between the census taking hour (12:00 midnight) on two (2) successive days. The following procedure illustrates the proper method of determining the number of resident days resulting from care rendered to residents in the facility, using the midnight census method:
      1. Number of residents in the facility at midnight
      2. Add/subtract residents admitted/discharged (including deaths) prior to midnight of the following day (Exception - a resident admitted and discharged on the same day counts as a resident day.) The provider may bill for the date of admission, but not for the day of discharge.

(b) When pre-admission payments are received to insure a bed is kept open for a particular resident. The rationale for including these payments lies in the fact that this bed is not available for occupancy by another resident. Since the facility is receiving payment for a bed which is, in effect, unavailable to any other resident, it should be included in resident day totals.

(c) When a resident is out of the facility, regardless of the reason, and the facility is receiving payment for the bed, this day is counted in the same manner as pre-admission payments as stated above. If the facility is not receiving payment for the bed, it will not be counted as a resident day.

(d) Medicaid payments to ICF/MRs for therapeutic visits will be limited to 14 days per calendar month, not to exceed 14 consecutive days at one time.

2. Minimum records required to be kept at the facility are:

(a) Midnight census by resident name at least one time per calendar month. More frequent census taking is recommended.

(b) Ledger of all admissions and discharges/deaths.

(c) Complete therapeutic leave records.

(d) A monthly analysis sheet which summarizes all admissions and discharges, paid hold bed days, and therapeutic leave days. (Schedule 6A at the end of this Chapter is the recommended analysis sheet, however, providers may utilize any form of their own design which provides the same information.)

3. In the event that payment for a pre-admission day is not received and the charges are subsequently written off as uncollectable, the facility will not count those days as resident days. The facility must keep a separate ledger to indicate days in this category. The ledger must indicate the following:

(a) Resident name

(b) Dates of pre-admission days charged

(c) Dates of preadmission days written off as uncollectable

(d) Reason for uncollectability

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.250-.255 et seq. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.07. Management and Administrative Costs.

1. Costs of a management or administrative nature, including but not limited to those costs outlined in Rule No. 560-X-42-.07(3), will be reported as such on the Medicaid Cost Report. Salaries of administrative personnel which would duplicate employee salary expenses in other cost centers cannot be allocated to such non-administrative cost centers. Administrative compensation is limited to 10% of net allowable other cost, plus use allowance (if applicable).

2. Customarily, owner compensation results from a distribution of the profits. However, when the owner provides a necessary service to the facility, and he/she can justifiably be compensated at a reasonable rate, then that owner compensation is an allowed cost. "Reasonable compensation" must meet the criteria of being paid to an employee who performs a necessary function in a facility and must be in an amount which would ordinarily be paid for comparable services in a comparable facility. To be "necessary," a function must be one that if that employee were not performing it, another would have to be employed to do so, and additionally, the function must be directly related to providing ICF/MR services.

3. Examples of Allowable Management and Administrative Costs include, but are not limited to:
   - (a) Salaries and Bonuses
     1. Administrator
     2. Assistant Administrator
     3. Accountant
     4. Bookkeeper
     5. Computer Operator
     6. Medical Records Clerk
     7. Personnel Officer
     8. Secretary
     9. Typist
     10. Clerks
     11. Receptionist
     12. Telephone Operator Switchboard
   - (b) Legal Fees (Legal fees related to resident care, except those specified in Rule No. 560-X-42-.19)
   - (c) Outside Accounting and Auditing
     1. Routine Bookkeeping
     2. Preparation of cost reports
     3. Auditing and related statements
   - (d) Data Processing
     1. Owned
     2. Rented
     3. Outside purchased service
   - (e) Professional Development
   - (f) Supplies
     1. General administration
     2. Medical records
   - (g) Telephone Expense - Subject to limitations in Rule No. 560-X-42-.19(u).
   - (h) License
     1. Business
     2. Administrator's
   - (i) Insurance
     1. Professional Malpractice (limited to provisions in HIM-15, 2163.3)

(j) Employee Benefits - Administrative Employees

1. Group Life
2. Group Health
3. FICA
4. SUI
5. FUTA
6. Deferred Compensation Plans, Pension and Profit Sharing, approved by IRS
7. Workmans Compensation Insurance (Non-State owned and operated facilities)

(k) Advertising

1. Telephone, local (not in excess of 5 square inches in yellow pages)
2. Employment ads
3. Public Relations ads (not in excess of $100.00 per fiscal year).

(l) Postage

(m) Management Home Office Cost (chain operation)

1. Management and administrative salaries and benefits.
2. All building costs, including but not limited to:
   - i. Insurance
   - ii. Rent
   - iii. Lease
   - iv. Utilities
   - v. Depreciation
   - vi. Interest

(n) Interest Expense on working capital loans, subject to limitations contained in Rules No. 560-X-42-.08 and 560-X-42-.19(3)(q).

(o) Management fees not exceeding the cost of the provider of the services and not excluded under Rule No. 560-X-42-.19(3).

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.08. Interest Expense.

1. Necessary and reasonable interest expense is an allowable cost. In order to be considered necessary, the interest must be incurred on a loan made to satisfy a financial need directly related to resident care. Loans which result in excess funds or which are not related to resident care are not considered to be necessary. In order to be considered reasonable, the interest rate cannot be in excess of that which a prudent borrower would agree to pay, and the lender must not be related to the borrower. The provisions of HIM-15 (Medicare Provider Reimbursement Manual) shall be applicable in determining whether a loan is between related parties. Interest paid by the provider to owners, partners, stockholders, or other persons related to the provider is not an allowable cost. However, the principal amount of such loans will be included in equity capital for the purpose of computing the return on equity payable to proprietary providers. This will be done in computing a proprietary provider's return on equity, by eliminating the liability from the deduction from assets, thereby increasing the equity.
2. Bond discounts or premiums will be amortized over the life of the bond issue using the straight line method and such amortization will be treated as interest. Amortization will be added to interest expense in the case of discounts and deducted from interest expense in the case of premiums.

3. Interest incurred during the period of construction on funds borrowed to construct or enlarge existing facilities must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for resident care. Where a bond issue is involved, any bond discount and expense, or bond premium amortized during the period of construction must be capitalized and included in the cost of the facility constructed.

   If a debt which was incurred to finance the construction, expansion, renovation or acquisition of an ICF/MR facility is refinanced, allowable interest on the refinanced portion of the original loan will be limited to the interest which would have been allowed under the original financing arrangement, and any additional interest on the refinanced portion will be an unallowable cost.

4. If the provider incurs a prepayment penalty on the early extinguishment of an interest bearing debt, the amount of such interest penalty shall be allowable and treated as interest expense using the following guidelines:

   (a) If accumulated interest plus penalty is less than the amount of interest that would have been incurred had the debt not been paid off, then all the interest and penalty can be claimed.

   (b) If the interest and penalty exceed the amount of interest that would have been claimed had the debt not been paid off, then only the amount that would have been claimed during a reporting year can be included in the cost report. The excess penalty will be carried on the balance sheet as an asset and written off in subsequent years in a manner such that annual interest claimed does not exceed what the actual expense would have been.

5. The payment of a lease payment to a Medical Clinic Board under a lease agreement containing a purchase option at a price below the fair market value is generally not allowable as a true lease payment, therefore the portion of the "lease payments" equal to the interest payments in the underlying bonds is subject to the limitations on reimbursement of interest expenses normally allowable as an interest expense.

6. Interest must be reported on the cost report in two distinct areas: working capital interest, in the administrative cost center, and other interest reported in the property cost center.

   (a) Working capital interest is limited to short term loans taken out to meet immediate needs of daily operations. If no evidence of repayment of these loans is apparent and a note is merely renewed or continued throughout the year, Medicaid will not consider these notes to be bona fide working capital loans, and interest expense will not be reimbursable. If these short term notes are repaid or a genuine effort has been made to repay them, interest expense will be limited to 90 days interest on two months of the provider's average allowable cost adjusted for depreciation and/or rent expense. The interest rate used for this computation will be the average rate charged by the lender during the year.

   (b) Other interest includes mortgage interest and interest on loans to purchase equipment. The provider is required to have on file records to support the date, amount, and purpose of each loan. If the loans are of the installment type, an amortization schedule should also be available for inspection.

7. Only interest expenses incurred and payable to a lender, as evidenced by a signed loan agreement, will be considered for reimbursement. Additional interest expense created by restatement of a loan agreement, under generally accepted accounting principles or created by imputing interest is not reimbursable. For example, an imputed interest expense resulting from the application of Accounting Principles Board Opinion No. 16 or No. 21, or any similar accounting principle, and any other imputed interest expense shall not be recognized as an interest cost for purposes of computing the provider's allowable Medicaid reimbursement.

8. If financing is obtained to purchase a facility, only the portion of the loan which pertains to the allowable purchase price, as defined by Medicaid, will be allowable. If this financing is a combination of assumed debt and other debt, the priority of allowability is as follows:
    (a) Assumed debt at the stated rate
    (b) Additional debt at the stated rate
    (c) Other debt
9. If loans are made to related parties during the reporting period and working capital loans are created or remain outstanding during any period in which the related party loans are outstanding, then the interest on the portion of the principal amount of such working capital loans equal to the principal amount of such related party loans is not reimbursable.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.09. Laundry Expense.

1. Allowable costs will be limited to the laundry costs which are ordinary and necessary to the operation of an ICF/MR facility and will not include costs associated with the personal laundry of residents (if the facility charges for resident personal laundry).
2. Examples of such costs include, but are not limited to, the following:
    (a) Laundry salaries and employee benefits attributable to laundry personnel
    (b) Supplies and materials used in providing laundry services
    (c) Depreciation on equipment used in providing laundry services
    (d) Costs directly attributable to the delivery of laundry
    (e) Charges by an outside laundry.
3. Allowable salaries and benefits will include all personnel directly involved in performing this service. Delivery costs will be subject to the limitation in Rule No. 560-X-42-.10, "Travel Expense".
4. If the facility charges for resident personal laundry, the total cost of handling the personal laundry must be deducted from actual laundry costs. If this cost cannot be separated from other laundry costs, two (2) one-week laundry studies based on weight must be conducted by the facility at six (6) month intervals. The laundry costs will then be reduced by the personal laundry proportion as determined by the studies.
5. If a facility elects not to charge sponsors or residents a personal laundry charge, Medicaid will not deduct a percentage of total laundry costs from the facility's rate computation.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.10. Travel Expense.

1. Travel that is necessary and that is directly related to the operation of the ICF/MR facility claiming reimbursement for the expense will be an allowable cost for reimbursement purposes pursuant to the following specific provisions.
    (a) Automobile (This section (a) does not apply to State owned and operated facilities). The reasonable costs of automobile travel necessary for the maintenance of resident care shall be considered for purposes of reimbursement to facilities owned and operated by the State.
        1. Since the form of vehicle ownership, the type, and the number of vehicles utilized will vary depending on a facility's specific needs, reimbursement will be based on a standard mileage rate and will be limited to mileage which is documented by log entries prepared in accordance with either of the attached sample logs. (See Schedules 10A and 10B found at the end of this Chapter.)

2. All log entries must be made at the time of travel, and log entries will be subject to verification during audit. Failure to timely and accurately account for travel mileage will result in a disallowance of this cost.
3. Commuting mileage between the commuter's residence and the ICF/MR facility is not allowable mileage for reimbursement purposes. (See Schedule 10A at the end of this chapter.)
4. The standard mileage rate is as follows: The IRS mileage rates in effect on January 1 of the calendar year in which the cost report is filed. These rates will be applied on a per provider basis regardless of the number or type of vehicles used. (See Schedule 13-B at end of chapter.)
5. In addition to the mileage rate listed above, up to $1,000.00 in actual operating costs (i.e., gas, oil, upkeep) per vehicle may be reimbursable. Medicaid will also allow depreciation of the cost of a new vehicle. Depreciation must be on the Straight line method for five years. There will be no additional reimbursement in those instances in which the facility auto is used for commuting purposes of the administrator or non-resident care related activities. To qualify for this additional allowance, the facility must own a vehicle, the vehicle must be used only for purposes of resident care, and actual operating expenses must exceed the computed mileage allowances. In no instance will the facility be allowed to claim more than the standard allowance plus the $1,000 (if computed allowance is less than operating cost) or actual operating costs, whichever is less.

Examples:

Facility Owns Vehicle	Medicaid Mileage Allowance	Actual Operating Expense	Allowance
Yes	$ 2,325	$ 2,115	$ 2,325
Yes	2,325	4,125	3,325
Yes	2,325	2,765	2,765

6. If the facility does not own a vehicle, reimbursement will be limited to actual payments to employees for use of their personal automobiles for documented facility business, provided that such reimbursements do not exceed the allowable rates. (IRS guideline)
7. No additional reimbursement in excess of $1,000.00 will be recognized for any other automotive-related cost. Those additional costs which will not be recognized include, but not limited to:
   i. Insurance
   ii. Interest on automotive loans
   iii. Lease/rental expense
   iv. Taxes and tags
   v. Return on equity
8. No reimbursement will be made or considered for unusual or impractical vehicles, which include but are not limited to aircraft, motorcycles, farm equipment and other vehicles not necessary to the efficient operation of the facility.

(b) Other travel

1. Costs of travel to out-of-state conventions or association meetings will be limited to those reasonable costs incurred by a facility for two trips during each fiscal year. If

the facility bears the expenses of two persons attending the same convention or association meeting, such attendance will be counted as two trips.

2. Transportation expenses in or out-of-state will be limited to the ordinary and necessary costs of transportation, food, lodging, and required registration fees.
3. Whenever out-of-state travel could be accomplished at a lower cost by utilizing air travel, reimbursement will be limited to the costs which would have been incurred if such air travel had been utilized and the costs normally incident to such air travel (meals, lodging, etc.).
4. No travel expenses of a non-business nature will be reimbursed.
5. Travel which requires an overnight stay must be documented by a travel voucher which includes the following:

   i. Date

   ii. Name of person

   iii. Destination

   iv. Business purpose

   v. Actual cost of meals and lodging

   (lodging must be supported by invoices, meal receipts must indicate number of meals served for any meal in excess of $10.00).

   vi. Air, rail and bus fares (supported by an invoice)
6. Costs incurred in travel outside the United States will not be reimbursed.

Authority: State Plan; Title XIX, Social Security Act; 42C.F.R., Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.11. Property Costs.

This rule does not apply to State owned and operated facilities who are paid a use allowance in lieu of depreciation for buildings and improvements. The annual use allowance for buildings and improvements shall be two percent of acquisition cost. Major movable equipment for State owned and operated facilities will be depreciated as in paragraph (10) of this rule.

1. Medicaid Approval. The construction, sale or lease of any ICF/MR facility must be approved by Medicaid for purposes of Medicaid reimbursement. Medicaid may, at its option, elect not to approve any new construction, sale or lease of a facility entered into without its prior approval; in which case, Medicaid will not reimburse any property costs. Capital expenditures must be approved under applicable Certificate of Need regulations by appropriate state and/or federal agencies. When construction is accomplished without such approval, Medicaid will be able to pay only operating costs; capital expenditures will not be an allowable cost in these cases, as further explained in Rule No. 560-X-42-.04(3).
2. New Construction. Construction costs as defined in Rule No. 560-X-42-.11-(9) will be reimbursed on actual cost up to a maximum of $16,600.00 per bed. This limitation is intended to discourage construction of lavish facilities.
3. Land. The maximum allowable cost assigned to land upon which a newly constructed facility is built, or upon which a purchased facility is located, shall use as a guideline an amount not to exceed 5% of the construction costs (with respect to a newly constructed facility) or of the allowable basis determined pursuant to Rule No. 560-X-42-.11(4) with respect to a purchased facility) absent a showing by the provider that the 5% is not a reasonable amount. Each such construction or purchase situation shall be subject to the "prudent buyer" concept with each case to be considered on its own merits.
4. Sale of Existing Facilities. Effective for sales closed on or after October 1, 1988, the allowable basis to the purchaser of a facility participating in the Medicaid program of those assets which would be includable as construction costs pursuant to Rule No. 560-X-42-.11(9) if the facility were being constructed rather than purchased, shall be the lower of:

(a) The actual sales price negotiated for the purchase of the facility. For purposes of this Rule, including but not limited to this section (a) and Section (7)(a) of this Rule, sales price shall mean the total price agreed upon by the seller and purchaser as evidenced by a signed copy of a final sales agreement. The stated sales price agreed to by the seller and the buyer shall not be reduced by any discount involved with issuance, by the purchaser of notes, mortgages, bonds, or securities, and the acceptance of such debt instruments as part of the agreed upon purchase price by the seller; or

(b) The current replacement cost of the facility [based upon the current Alabama Medicaid ceiling on Construction Costs of new facilities under Rule No. 560-X-42-.11(2) reduced as follows:

Age of Facility	Write Down
1 - 10 yrs.	2.5% per year for each year of age up to 10 years
11 - 15 yrs.	25% plus 2.0% per year over 10 years
16 - 25 yrs.	35% plus 1.5% per year over 15 years
26 or older	50% plus 1.0% per year over 25 years

For purposes of this subsection (b), fractional years shall not be counted. Also, the maximum allowable basis of a facility, portions of which have been constructed at different times, will be calculated by considering separately each area of the building constructed at different times.

Example: Valuation of a 100 bed facility held 15 years

100 beds x $16,600 = $ 1,660,000

Less: Depreciation

[($1,660,000 x 35% (25%)+(2%x5)=35%] (581,000)

Maximum allowable depreciable basis $ 1,079,000

Land (limited to 5% of depreciable basis) 83,000

(prior to write down, if applicable)

Total Allowable Basis $ 1,162,000

or;

(c) A purchase price which would represent an increase over the sales price paid by the seller of one-half of the percentage increase, from the date of acquisition by the seller to the date of sale by seller, in the Dodge Construction Systems Costs for Nursing Homes; or

(d) A purchase price which would represent an increase over the sales price paid by the seller of one-half of the percentage increase, from the date of acquisition by the seller to the date of sale by seller, in the Consumer Price Index for all Urban Consumers (United States city average).

5. Seven Year Rule. No increase in property costs resulting from a change in ownership will be allowed for reimbursement purposes for a period of seven (7) years after the last change in ownership that resulted in a revaluation of depreciable basis or after the original construction of the facility. If a change occurs, reimbursement to the new owner will be under the same terms as under Rule No. 560-X-42-.11(11) related to non bona fide sales. Medicaid will consider granting exceptions to this seven (7) year rule, but only in cases of extreme hardship, such as death of the owner. Requests for such exceptions should be submitted in writing to the Commissioner of the Alabama Medicaid Agency and should be fully documented.
6. Leases. The maximum lease payment which will be considered an allowable property cost will be the lower of (a) or (b), as follows:
   (a) The actual lease payments which lessee is obligated to pay to the owner; or
   (b) For net leases, 12% of the replacement cost of the facility [based on the current Medicaid ceiling on construction costs of new facilities under Rule No. 560-X-42-.11(2) adjusted as provided under Rule No. 560-X-42-.11(4)]. In those cases in which the depreciable assets have been stepped-up within the immediately preceding seven years, the 12% shall be applied to the net depreciated allowed book value at the date of the lease agreement.
   (c) Leases submitted to the Agency for approval must be specific as to the responsibility for payment of fire and casualty insurance and property taxes. The maximum allowable lease payment calculated in (b) above includes an allowance for taxes and insurance.
   (d) Sale/Leaseback Transactions. Reimbursement of rental or lease payments for these type transactions will be limited to the lower of: 1. the costs (depreciation, interest) of ownership which the facility would have been reimbursed had it retained legal title to the assets, or 2. the allowable Medicaid lease payment.
7. Depreciation Recapture.
   (a) Prior to Agency approval of the sale of a facility which has previously participated in the Medicaid program, all depreciation previously allowed and reimbursed through the per diem rate attributable to periods subsequent to the later of October 1, 1980, or the last recapture date will be recaptured. If the facility was sold at a price in excess of the sellers' cost of the property as reduced by accumulated depreciation, as computed under Medicaid depreciation guidelines, the recapture amount will be the lesser of the sellers' actual gain on the sale or the amount of the depreciation previously reimbursed through the per diem rate. Any gain based on the stated sales price agreed to by the seller and the buyer shall not be reduced by any discount involved with issuance by the purchaser of notes, mortgages, bonds, or securities, and the acceptance of such debt instruments as part of the agreed upon purchase price by the seller.
   (b) Recapture of depreciation is not applicable in those instances where a stepped-up basis is not allowed, whether refused or is unallowable by the seven (7) year rule, or any other provisions of the regulations. Any subsequent sale, which results in a purchaser assuming a stepped-up basis, shall be subject to depreciation recapture from the later of October 1, 1980, or the last recapture date. The amount of recapture otherwise due to Medicaid from the seller of a facility which has been used in the Medicaid program will be ratably reduced commencing after that seller (regardless of that seller's method of acquisition) has owned the facility for 7 full years, at the rate of 1.04167% per month (being an annual rate of 12.5%). This reduction will result in no recapture being due once an owner has owned a facility for 15 full years. Each subsequent sale or other transfer of ownership is subject to a fifteen year holding period before the amount subject to recapture is reduced by 100%.
   (c) If the seller's allowable costs during the seller's participation in the Medicaid program have in any year(s) exceeded the overall ceiling, the amount of depreciation subject to recapture will be determined as follows:

1. For any such fiscal year between October 1, 1980, and the date of sale, the amount of depreciation subject to recapture for each such year will be determined as follows:

   i. Reimbursement ceiling divided by average otherwise allowable cost per day (as shown on the rate computation schedule) = Reimbursement percentage.

   ii. Reimbursement percentage x depreciation x Medicaid occupancy = Amount of Recapture.

   iii. For partial fiscal years, the computation will be prorated based upon the number of full calendar months included in the partial year.

(d) Recapture will take the form of a lump sum repayment by the seller to Medicaid of the amount of depreciation computed under the depreciation recapture provisions as set out herein above. However, when Medicaid is requested to approve the sale of a facility wherein no arrangements are made for such a depreciation recapture payment by the seller, Medicaid may, notwithstanding any other provision of this section, withhold all reimbursement otherwise due to the purchaser until such recapture repayment is fully recaptured from reimbursement otherwise payable to the purchaser.

(e) As to periods subsequent to October 1, 1980, during which a facility is leased to a Medicaid provider, and therefore, no depreciation is claimed as such for purposes of Medicaid reimbursement, the depreciation allowance which would have been reimbursable to the owner of the facility during the term of the lease if the owner had also been the provider will be computed. The amount so computed will be treated as "imputed depreciation" and will be subject to recapture from the seller as though such depreciation had been actually claimed and allowed for Medicaid reimbursement during the lease period. Medicaid will not approve the sale of a facility which has been leased until it is provided with adequate records (such as, but not limited to, federal income tax returns) from which it can compute the amount of "imputed depreciation."

8. Facilities Financed by Bond Issues. Medicaid will treat the lease of a facility which has been financed by a Medical Clinical Board bond issue, pursuant to which the "lessee" has an option to purchase at less than market value, as a lease purchase agreement for reimbursement purposes. In these instances, the lessee's allowable property costs will be limited to the amount which would be allowable if the lessee had legal title to the facility's assets (the owner's allowable property costs) such as straight line depreciation, insurance, property taxes, interest, and an equity return on the investment in property, plant and equipment related to patient care, net of depreciation, and loans. The return on equity capital is subject to the provisions in Rule No. 560-X-42-.13.

9. Definition of Construction Costs. "Construction Costs" include the cost of:

   (a) Buildings. Buildings include, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

   (b) Building Equipment. Building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are that it normally: (1) is affixed to the building and not subject to transfer; and (2) has a relatively long useful life, but the useful life is shorter than the useful life of the building to which affixed.

   (c) Major Movable Equipment. Major movable equipment includes such items as beds, wheelchairs, desks, etc. The general characteristics of this equipment are that it: (1) has a relatively fixed location in the building; (2) is capable of being moved, as distinguished from building equipment; (3) has a unit cost sufficient to justify ledger control; and (4) has sufficient size and identity to make control feasible by means of identification tags.

   (d) Land (Non-depreciable). Land (non-depreciable) is excluded from Construction Costs for purposes of the limitations on Construction Costs contained in Rule No. 560-X-42-.11(2). However, allowable land costs are subject to the limitation contained in Rule No. 560-X-42-.11(3).

(e) Land Improvements (Depreciable). Depreciable land improvements include paving, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc., if replacement is the responsibility of the provider.

(f) Capitalized Costs. Construction period interest and other expenses which are normally capitalized as part of the cost of the acquired property under generally accepted accounting principles.

(g) Acquisition costs such as feasibility studies, accounting fees, legal fees, etc., are not reimbursable costs for sales occurring on or after October 1, 1988.

10. General Principles Relating to Property Costs. Property Costs include, but are not limited to, depreciation, interest, lease and rental payments, insurance on buildings and contents, and property taxes. In addition to the limitations contained in this Rule No. 560-X-42-.11, all property costs will be subject to the "prudent buyer" concept with each case to be considered on its own merits. Also, depreciation, interest, rent, insurance, and taxes associated with space and equipment used for non-covered services or activities must be eliminated from allowable property costs. Treatment of costs associated with the operation of a laundry is dealt with in detail in Rule No. 560-X-42-.09.

(a) Depreciation

1. In order to be allowable as a property cost, depreciation must be: (a) identifiable and recorded in the provider's accounting records; (b) based on the allowable historical cost of the asset; and (c) prorated over the estimated useful life of the asset using the straight line method. The useful life guidelines published by the American Hospital Association must be followed in establishing the useful life of a new asset. (See Schedule 11A at the end of this chapter.) The Agency may allow lives different from these guidelines, if the provider requests consideration in writing. Medicaid may allow used assets to be depreciated over shorter estimated useful lives if prior approval of such shorter useful lives is requested in writing by the provider. If such prior approval is not obtained, used assets will be depreciated over the same useful lives as established for new assets. For those assets not appearing on Schedule 11A at the end of this chapter, Medicaid will establish the appropriate useful life on a case-by-case basis.

2. The costs of improvements, including major leasehold improvements such as building additions, will be depreciated over the useful life of the improvements, regardless of the remaining term of any lease agreement.

3. Any gain attributable to periods during which a provider has participated in the Medicaid program, resulting from the disposal of equipment will be used to offset depreciation expenses for the year in which the gain is realized. Any loss attributable to periods during which a provider has participated in the Medicaid program and resulting from such a disposal will be added to allowable costs for the year during which the loss is realized. In determining the gain or loss, such gains or losses will be treated as having accrued ratably over the entire period during which the provider has owned the asset. The allowable aggregate amount of such gains and losses will be limited to 10% of the provider's total allowable depreciation for the year during which such gain or losses are realized. Any amounts in excess of this 10% will be carried forward to subsequent years, with the same 10% limitation applying until the total gain or loss is absorbed into an allowable cost year. No gain or loss will be recognized for purposes of this section from a trade-in of a depreciable asset. Refer to Rule No. 560-X-42-.11(10)(a)4, for an explanation of the basis to be utilized whenever an asset is traded in.

4. Trade-Ins. When an asset is acquired by trading in an asset that was depreciated under the program, the basis for purposes of depreciation of the new asset will be the sum of the undepreciated balance of the old asset and the cash paid or to be paid.

(a) Interest. Subject to the provisions of Section 10 of this Rule, necessary and reasonable interest incurred to finance the purchase or construction of a facility, to purchase equipment, and to finance the cost of major repairs and renovations, is an allowable property cost. Interest on the portion of a loan which exceeds the construction or purchase price approved by Medicaid for the financed asset will not be included in property costs, but will be subject to the other interest provisions of Rule No. 560-X-42-.08. If an asset is refinanced by a current owner at a higher rate of interest, allowable interest on the refinanced portion of the original loan will, unless the entire interest expense meets the necessary and reasonableness tests of Rule No. 560-X-42-.08, be limited to the interest which would have been allowed under the original financing arrangement. The excess interest on the refinanced portion will be an unallowable cost.

(b) Leases and Rental Payments. All major lease and rental agreements must be in writing and must be approved by Medicaid for Medicaid reimbursement purposes prior to the signing by the provider. Medicaid will, in all cases, exclude from the provider's allowable costs all lease payments made or accrued prior to Medicaid approval of the lease agreement. Medicaid may, however, at its option, elect not to reimburse any lease payments under, or any other property costs incurred in connection with, any lease entered without its prior approval.

1. Facility Leases. Leases will be subject to the "prudent buyer" concept with each case to be considered on its own merits. Factors considered by Medicaid in its review will include, but not be limited to, the age of the facility, current costs versus proposed costs, length of lease, existing debt service, and fair return to lessor. No lease will be approved which contains a "percentage of the gross" or "escalator" clause. The fact that a lease is being renegotiated will not be grounds for increasing the amount of the lease payment. Medicaid reserves the right to require an independent appraisal of the leased facility at the expense of the provider by an appraiser selected by Medicaid. For Medicaid reimbursement purposes, allowable rental payments between related parties cannot exceed the lessor's allowable property costs. Subleases which include payment in excess of that being made by sublessors will not be honored as to the additional payments. No increase in a lease payment will be recognized if an increase in lease payment or an increase in property costs due to the sale of the facility has occurred during the immediately preceding seven (7) year period. Medicaid will consider granting exceptions to the seven (7) year rule, but only in cases of extreme hardship, such as the death of the owner. Requests for exceptions should be submitted in writing to the Commissioner of Medicaid and should be fully documented.

2. Equipment Rental. Reasonable costs of such rental equipment as is normally and traditionally rented by health care institutions and which is rented from a non-related organization, are allowable provided the arrangement does not constitute a lease-purchase agreement. All items leased under a lease-purchase agreement must be capitalized and depreciated over the useful life of the asset.

(c) Insurance on Building and Contents. The reasonable costs of insurance on buildings and their contents used in the rendition of covered services purchased from a commercial carrier and not from a limited purpose insurer [Ref. HIM-15, Section 2162(2)] will be considered as allowable costs.

(d) Property Taxes. Ad Valorem and personal property taxes on property used in the rendition of covered services are allowable under this section. Fines, penalties or interest related to those taxes are not allowable.

(e) Life and Rental Insurance. Premium payments for life insurance required by a lender or otherwise required pursuant to a financing arrangement will not be an allowable cost. Loss of rental insurance will also be considered an unallowable cost.

(f) Minor Equipment is not subject to the provisions of this Section. Minor equipment must be expensed as of the date of purchase. Minor equipment includes such items as waste baskets, bed pans, catheters, silverware, mops, buckets, sheets, towels, etc. The general characteristics of this equipment are (1) no fixed location and subject to use by various departments of the provider's facility; (2) comparatively small in size and unit cost; (3) subject to inventory control; (4) fairly large quantity in use; and (5) a useful life of approximately three years or less.

(g) Capitalization Level. Any asset with a per unit cost of $500 or more with an expected useful life of three years or more must be capitalized. Any group purchase of assets (i.e., 10 mattresses, 4 beds, etc.) with an aggregate cost of $1,000 or more with an aggregate expected useful life of three years or more must be capitalized.

11. Non Bona Fide and Related Party Sales.

    (a) Non Bona Fide Sales. If a facility changes ownership and a purchaser cannot justify that the sale was bona fide, the seller's book value shall be used by the purchaser as the basis for the depreciation of the purchased assets. In such cases, the purchaser shall record the historical cost and accumulated depreciation of the seller recognizable under the program, and these shall be considered as incurred by the purchaser for program reimbursement purposes. No additional interest expense or return on equity resulting from such a non bona fide sale will be reimbursable.

    (b) Related Party Sales. Any sale between a provider and a "related party" will not be deemed a bona fide sale. The purchaser's cost basis in depreciable assets and the remaining depreciable life of assets purchased will be the same as that of the seller. The portion of the purchase price reasonably allocated to assets which is in excess of the seller's book value shall be entered as a separate item on the books of the purchaser and eliminated from the computation of allowable interest expense, allowable depreciation and return on equity capital for the purposes of Medicaid reimbursement. The provisions of HIM-15 shall be applicable in determining whether a sale is between related parties.

12. Rate Computation. The allowable property costs (as defined in this section) will be added to the allowable other costs and return on equity capital for determination of the 90th percentile.

13. Transactions Involving Corporate Stock. The purchase of the stock of a corporate provider will generally not be considered as a purchase of the provider's assets; therefore, such a stock purchase will not result in a revaluation of the assets of the provider. However, such a revaluation will be permitted upon the statutory merger or consolidation of the corporation provider with another corporation under the same circumstances wherein such a revaluation would be permitted by 42 CFR Section 413.134(k). Additionally, a revaluation of assets will be permitted where the purchase of stock of a corporate provider is followed within three (3) months by the liquidation of the provider. Any revaluation of the assets of a provider as the result of such a statutory merger, consolidation, or liquidation shall be subject to the same prior approval and basis limitations as though an outright sale of the assets has been made.

14. Changes in Ownership. In a transfer which constitutes a change of ownership, the old and new providers shall reach an agreement between themselves concerning trade accounts payable, accounts receivable and bank deposits. Medicaid will pay the new provider for unpaid claims for services rendered both prior to and after the change of ownership. The new provider shall be liable to Medicaid for unpaid amounts due or which become due Medicaid from the old provider.

15. Bed Additions or Replacement Beds. It is anticipated that bed additions to existing facilities will cost less than new facilities since these additions generally do not require additional administrative, dietary, and plant operation areas. Bed Additions or replacement bed construction costs built at the same location as the core facility will be reimbursed on an actual cost basis using $12,000 per bed as a reasonable guideline. This limitation is intended to discourage construction of lavish facilities. Appropriate adjustments to this $12,000 per bed cost limitation may be made based on the availability of service areas in the existing facility.

16. Renovations. Renovations to the existing facility will be reported as a separate cost breakdown.
17. In those instances wherein a facility that is being leased is sold, the purchaser of the facility must furnish the Agency with documentation of the seller's actual facility acquisition cost prior to Medicaid computation of an allowable depreciable basis.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250 - .255, et seq. Rule effective October 13, 1988. Amended September 13, 1989, and July 13, 1993. Effective date of this amendment is March 14, 1996.

Rule No. 560-X-42-.12. New Facility or Change in Ownership.

1. A provider who constructs, leases, or purchases a facility may request reimbursement based on an operating budget, subject to the ceiling established under Rules Number 4 and 5 of this Chapter. In this event, the facility will be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. These actual allowable costs will be reported on a complete interim cost report. If this interim report should span September 30, the Agency may accept this report as the interim and regular cost report in this instance, the report will be used to settle the budgeted period and also to set the next year's prospective rate. If the Agency accepts this report as the September 30 regular report, the due date shall be November 30; if not, the due date will be 60 days after the end of the interim period as specified by the Agency.
2. The difference between budgeted and/or projected costs in these instances will be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference.
3. Upon voluntary or involuntary complete withdrawal of a facility participating in the Medicaid program, the provider will be subject to a retroactive adjustment based upon the difference between the amount of reimbursement paid by Medicaid and the actual allowable costs incurred by the former provider during the following periods:
   (a) If the effective date of the withdrawal is less than six (6) months after the preceding October 1st, a retroactive adjustment will be made for the current fiscal year and for the immediately preceding fiscal year.
   (b) If the effective date of the withdrawal is six (6) months or more after the preceding October 1st, a retroactive adjustment will be made for the current fiscal year only.
4. Providers who terminate their participation in the Medicaid Program, by whatever means, must provide a written notice to the Agency thirty (30) days in advance of such action. Failure to provide this written notice shall result in a one hundred dollar ($100) per day penalty being assessed for each day short of the 30 day advance notice period (up to a maximum of $3,000). Terminating providers must file a final cost report within sixty (60) days of terminating their participation in the program. Final payment will not be made by the Medicaid Agency until this report is received. Failure to file this final cost report will result in Medicaid deeming all payments covered by the cost report period as overpayments until the report is received. Additionally, a penalty of one hundred dollars ($100) will be assessed for each calendar day that the cost report is late.
   (a) Terminating cost reports will be subject to audit and retroactive adjustment. Any adjustment will be paid or recouped by a lump sum payment.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.13. Return on Equity Capital.

1. An allowance for reasonable return on equity capital invested and used in providing patient care is allowable as an element of the reasonable cost of services rendered by a proprietary provider.
2. Equity capital is the difference between the net assets and net liabilities of a provider, adjusted for any asset or liability not related to patient care and any other non-allowable item provided for elsewhere in this Chapter.
3. The amount of Net Working Capital (current assets minus current liabilities) which is includable in the computation of return on equity capital shall not exceed 1/9th of the provider's allowable costs for the fiscal year in issue.
4. Providers that are members of chain operations must also include in equity capital a proportionate share of the equity capital, whether negative or positive, of the home office and/or directly related organizations. Amounts due to and from members of a chain, the home office, or any related service organization must be eliminated in computing equity capital.
5. Unless specifically stated otherwise in this Chapter or HIM-15, current assets and current liabilities will be determined in accordance with generally accepted accounting principles. Accounts must be maintained by the accrual method of accounting in compliance with Rule No. 560-X-42-.21. Accounts not maintained accordingly will result in equity capital not being included in the provider's rate computation until the required documentation of those accounts is provided Medicaid. Examples of assets and liabilities included in the determination of equity capital are as follows:
   - (a) Cost of fixed assets such as land, buildings and equipment, reduced by accumulated depreciation
   - (b) Net working Capital (all other assets minus all other liabilities except specific exclusions)
     1. Assets
        - i. Cash on hand in banks
        - ii. Current accounts receivable will include only those accounts for which diligent, documented effort is being made to collect
        - iii. Notes Receivable
        - iv. Other Receivables
        - v. Inventory
        - vi. Deposits on Leases
        - vii. Bond Discounts (net amortization)
        - viii. Prepaid Expenses (except prepaid life and auto insurance premiums
        - ix. Other Assets
     2. Liabilities
        - i. Current Accounts Payable (payables over one year old may be adjusted as Medicaid deems necessary)
        - ii. Notes Payable
        - iii. Salaries and Fees Payable (must be paid within 75 days of the balance sheet date)
        - iv. Payroll Taxes Payable
        - v. Deferred Income (must be received within 75 days of the balance sheet date)
        - vi. Ad Valorem Taxes Payable
        - vii. Accrued Federal and State Income Taxes
        - viii. Accrued Expenses
        - ix. Bond Premiums (net of amortization)
        - x. Other Debts

6. Assets and liabilities not related to providing resident care are not includable in the provider's equity capital. Examples of excludable assets are as follows:
   (a) Funded Depreciation Account. Where the provider establishes an account in which amounts representing payments received or amounts accrued for depreciation expense are deposited, the amounts deposited in this account and the earnings on the funded depreciation which remain in the fund are not includable in equity capital.
   (b) Assets Held in Anticipation of Expansion. The costs attributable to land, buildings, or other assets held in anticipation of expansion are not includable in equity capital as long as they are not being used in the operation or maintenance of resident care activities. Liabilities related to these assets will also be excluded. Construction-in-process and liabilities related to such construction are not includable in equity capital.
   (c) Cash Surrender Value of Life Insurance. Where a provider carries life insurance on officers, owners, or key employees with the provider designated as the beneficiary, the cash surrender value of such insurance is not included in equity capital.
   (d) Prepaid Life Insurance. Prepaid premiums on life insurance carried by a provider on officers, owners, and key employees are not included in equity capital.
   (e) Goodwill. The costs of acquiring or generating good will is not includable in the provider's equity capital.
   (f) Prepaid Auto Insurance. That portion of a provider's general insurance premium that is prepaid and related to automobiles is not includable in equity.
   (g) Restricted Funds.
7. Accrued Federal and State Income Taxes will be treated as a liability in computing a provider's equity capital.
8. The portion of debts representing bona fide loans from partners, stockholders, or a related organization which is outstanding during the entire cost reporting period and on which interest payments are not allowable as costs is considered to be invested capital of the provider. By not subtracting it from assets, the equity capital of the provider is increased.
9. The rate of return on equity capital is a per annum percentage equal to the yearly average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund. These interest rates are available from the Social Security Administration on a monthly basis, and the average will be computed on a yearly basis for the twelve month period ending on the last day of the relevant cost reporting period.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.14. Qualified Retirement Plans.

1. The reasonable costs of funding "qualified" deferred compensation plans will be recognized as an allowable cost. "Qualified" deferred compensation plans means those plans which have been determined by the Internal Revenue Service to be qualified under Sections 401 or 405 of the Internal Revenue Code, as amended. Such plans can be generally categorized as either a defined benefit (hereinafter called "pension") or defined contribution (hereinafter called "profit sharing") plan.
2. Under a pension plan, the employer's contributions can be calculated based on the definitely determinable benefits provided for in the plan and such contributions are required without regard to the employer's profits. Pension plans typically provide that forfeitures resulting from termination of employees prior to their becoming one hundred percent (100%) vested in their account balance will be used to reduce further employer contributions, rather than being reallocated among the participants. The reasonable costs of a provider in funding such a pension plan will generally be considered as allowable costs, provided that the plan contains the usual provisions concerning use of forfeitures to reduce employer contributions (and therefore, Medicaid reimbursable costs). The portion of the provider's reimbursed costs under such plans which is attributable to the costs of funding the retirement benefits of employees whose compensation is includable in computing the

Administrative and Management costs of this Chapter will be considered as part of the compensation of each such employee during the year of contribution to the plan. For purposes of this Chapter, money purchase pension plans requiring that all forfeitures be used to reduce current or future employer contributions rather than increasing the benefits payable to the participants will be subject to the provisions of this paragraph relating to pension plans rather than the provisions relating to profit sharing plans.

3. A profit sharing plan is a deferred compensation plan, under which the contributions are based upon the profits of the employer and frequently are completely discretionary with the employer. Therefore, the contributions of the employer cannot be calculated based upon definitely ascertainable benefits to be provided to the employees. The employee, upon retirement, receives whatever amount is in his or her account on that date and is not guaranteed any certain level of retirement income.
4. Under a profit-sharing plan, forfeitures created by employees terminating employment who are less than one hundred percent (100%) vested in their account balances are typically reallocated to the other participants (including those employees whose compensation falls within the Administrative and Management costs), rather than reducing further contributions by the employer. Therefore, the actual operation of such profit sharing plans could result in a circumvention of the Administrative and Management cost center. Therefore, an employer's contributions to a profit sharing plan will generally be considered a reimbursable cost for Medicaid purposes only if all amounts credited to the accounts of participants who are credited with more than three (3) years of service under the Plan are nonforfeitable.
5. As with pensions plans, all contributions to profit sharing plans which are attributable to employees whose compensation is includable in computing Administrative and Management costs will be included in each such employee's compensation for the year during which the contribution is made to the plan for purposes of calculating the limitations imposed upon Administrative and Management costs under this Code. Provided, however, that in the event amounts attributable to previous Medicaid reimbursements are, under the "forfeiture" provisions of a profit sharing plan, reallocated from the account of an employee not coming under the Administrative and Management cost limitations to the accounts of employees whose compensation is included in computing such limitations, such amounts will be includable in the compensation of the employees to whose accounts such amounts are credited for purposes of computing the Administrative and Management costs for the year of reallocation.
6. Medicaid will not recognize employee stock ownership plans or stock bonus plans that were not both in operation and approved prior to October 1, 1980.
7. Other types of qualified retirement plans will be considered on a case-by-case basis by Medicaid utilizing the principles contained in this Section to the extent that such principles are consistent with the nature of such plans.
8. The accrual of costs by a provider under any unfunded deferred compensation arrangement will not be recognized as allowable costs for Medicaid Reimbursement purposes.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.15. Costs to Related Parties.

1. Allowable costs incurred by a provider for services or goods provided by Related Parties will not exceed the net cost of the services or goods to that Related Party, and that cost cannot exceed the fair market value of the items or services involved.
2. Under no circumstances will rent paid to a Related Party be includable in allowable costs. In such cases, lessor's costs, including an appropriate amount of equity capital, may be included in allowable costs provided that such costs do not exceed the fair market value of the leased assets.
3. The provisions of HIM-l5 shall be applicable in determining whether a Related Party relationship exists.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.16. Receipts Which Offset or Reduce Costs.

1. Certain income items or receipts must be used to either offset costs or reduce total reported costs. Typical, but not all inclusive, examples of such transactions are:
   - (a) Purchase discounts, rebates or allowances
   - (b) Recoveries or indemnities on losses (i.e., insurance proceeds)
   - (c) Sale of scrap or incidental services
   - (d) Sale of medical supplies (other than to residents)
   - (e) Medicare Part B - Income
   - (f) Sale of meals
   - (g) Vending machines
   - (h) Meal income (from meals served to guests or employees).
   - (i) Other expenses not appropriate in developing and maintaining adequate resident care facilities
   - (j) Contributions/donations
   - (k) Federal Revenue (Designated)
2. These items may be handled in either of two ways, at the option of the provider:
   - (a) The cost related to the income can be offset. If this option is selected, the provider must maintain adequate records to support the amount offset.
   - (b) If all costs associated with the income cannot be or are not identified separately on the cost report and in the provider's books and records, then the total income must be used to reduce total reported costs.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.17. Chain Operations.

1. A chain organization consists of a group of two or more ICF/MR facilities which are owned, leased, or through any other device controlled by related organizations or individuals. The home office of a chain organization is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The home office organization will be treated as a "related party" to participating ICF/MR facilities for purposes of this Chapter. Only the home office's actual cost of providing management services is permitted to be allocated to the providers and then only to the extent that they do not duplicate services already provided in the ICF/MR facility. Costs that would not be allowable if directly claimed by a provider will not be allowed as an allocation from a home office.
2. It is not considered appropriate for the taxpayers of Alabama to pay more for the operation of an ICF/MR facility owned or operated by a chain than would be paid for an individually operated ICF/MR. A chain operated facility is expected to be more efficient and economical to operate than an individually operated facility.
3. If a home office provides centralized laundry, maintenance, and purchasing services to facilities, the actual costs of providing these services will be charged to the facilities to which the services are provided. The facility will report these costs in the appropriate cost center on its cost report.
4. Maintenance, Central Purchasing, and Laundry
   - (a) Examples of home office costs associated with providing these services include:
     1. Maintenance
        - i. Salaries and Benefits
        - ii. Supplies
        - iii. Materials
        - iv. Travel expense subject to limitations contained in Rule 560-X-42-.10

2. Central Purchasing
   - i. Salaries and Benefits
   - ii. Goods
   - iii. Supplies
   - iv. Materials
   - v. Travel expense subject to limitations contained in Rule 560-X-42-.10
   - vi. Building Costs
     - (ii) Insurance
     - (iii) Rent
     - (iv) Lease
     - (v) Utilities
     - (vi) Depreciation
     - (vii) Interest
3. Laundry
   - i. Salaries and Benefits
   - ii. Supplies
   - iii. Materials
   - iv. Travel expense subject to limitations contained in Rule No. 560-X-42-.10
   - v. Building costs
     - (ii) Insurance
     - (iii) Rent
     - (iv) Lease
     - (v) Utilities
     - (vi) Depreciation
     - (vii) Interest

(b) Allowable salaries and benefits for these services will be limited to persons directly involved in performing such services. Allowable costs, as defined in this section, which can be identified to a specific member of the chain will be directly allocated to the proper cost center of that facility. The allowable costs not directly allocable should be allocated among the providers (and to any nonprovider activities in which the home office may be engaged) on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits from the costs and in a manner reasonably related to the services received by the entities in the chain. The costs of allocated building space must be used exclusively for these purposes and based on percentage of usage of total square feet. If a separate building is utilized, separate utility meters must be utilized.

5. Administrative Costs

   All costs incurred in maintaining a home office other than maintenance, central purchasing, and laundry costs will be classified as Administrative and Management costs and will be subject to the limitations contained in Rule No. 560-X-42-.07. Allocation of these costs to a facility will be on the basis of resident days.

6. Equity Capital

   See Rule No. 560-X-42-.13 of this Code.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.18. Cost Allocation.

1. Multiple use facilities will allocate all allowable costs which are not directly associated with a specific revenue producing department.
2. Examples of costs which are usually allocated include, but are not limited to:
   - (a) Depreciation
   - (b) Administrative and General
   - (c) Employee Health and Welfare
   - (d) Plant Operations
   - (e) Laundry and Linen
   - (f) Housekeeping
   - (g) Medical Records
   - (h) Dietary
   - (i) Social Services
   - (j) Pharmacy
3. Examples of revenue-producing departments are:
   - (a) Retirement Home
   - (b) Nursing Facility
   - (c) Hospital Facility

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.19. Unallowable Expenses.

1. General
   - (a) All payments to providers for services rendered must be based on the reasonable cost of such services covered by the Alabama State Plan. It is the intent of the program that providers will be reimbursed the reasonable costs which must be incurred in providing quality resident care. Implicit in the intent that reasonable costs be paid are the expectations that the provider seeks to minimize costs and that costs do not exceed what a prudent and cost-conscious buyer pays for a given item of service or product. If costs are determined to exceed the level that prudent buyers incur in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not allowable.
   - (b) Costs related to resident care include necessary and proper costs involved in developing and maintaining the efficient operation of resident care facilities. Necessary and proper costs related to resident care are those which are usual and accepted expenses of similar providers.
2. Costs that are covered by other State and/or Federal programs will not be allowed, and costs which are covered by other Alabama Medicaid Agency programs will not be reimbursed under the ICF/MR Program. Examples of such costs include, but are not limited to:
   - (a) Prescription Drugs (which can be billed by a state owned provider to the Pharmacy Program)
   - (b) Dental Expense (except consultant fees)
   - (c) Physicians' Fees other than the Medical Director
   - (d) Laboratory Expense for Residents (which can be billed by a laboratory to the Alabama Medicaid Laboratory Program)
   - (e) Ambulance Service

3. Administrative Costs Items which will not be allowed are listed below. This listing is not intended to be all inclusive. Other administrative costs which violate the prudent buyer concept or are not related to resident care will not be reimbursed by the Alabama Medicaid Agency.
   - (a) Management Fees
     1. Management firms, individuals and consultants which duplicate services already provided, or in a facility in which a full-time licensed administrator is employed.
   - (b) Director's Fees
   - (c) Compensation to owners and other personnel not performing necessary functions (See Rule No. 560-X-42-.07)
   - (d) Salaries which are paid personnel performing overlapping or duplicate functions
   - (e) Legal Fees and Expenses
     1. Retainers
     2. Relating to informal conferences and fair hearings
     3. Relating to issuance and sale of capital stock and other securities
     4. Relating to creation of corporations and partnerships
     5. Relating to business reorganization
     6. Services for benefits of stockholders
     7. Acquisition of ICF/MR facilities or other business enterprises
     8. Relating to sale of ICF/MR Facilities and other enterprises
     9. In connection with criminal actions resulting in a finding of guilt or equivalent action or plea
     10. Other legal services not related to resident care
   - (f) Outside Accounting and Audit Fees and Expenses
     1. Personal tax returns
     2. Retainers
     3. Relating to informal conferences and fair hearings
     4. Relating to issuance and sale of capital stock and other securities
     5. Relating to creation of corporations or partnerships
     6. Relating to business reorganization
     7. Services for the benefits of stockholders
     8. Acquisition for ICF/MR facilities or other business enterprises
     9. Relating to sale of ICF/MR facilities and other enterprises
     10. In connection with participation in criminal actions resulting in guilt or equivalent action or plea
     11. Feasibility studies, however, such fees may be capitalized as a Construction Cost under Rule 560-X-42-.11.
     12. Other Accounting services not related to resident care
   - (g) Taxes
     1. Personal income
     2. Property not related to patient care
     3. Corporate income tax
     4. Vehicle tag & tax
   - (h) Dues

1. Club
2. Civic
3. Social
4. Professional organization dues for individuals
5. Non-resident care related organization

(i) Insurance

1. Life
2. Personal property not used in resident care
3. On real estate not used in providing resident care
4. Group life and health insurance premiums which favor owners of a provider or are for personnel not bona fide employees of the facility

(j) Advertising in excess of the limitations of Rule No. 560-X-42-.07 of this Chapter.

(k) Chaplains/Spiritual Advisors

(l) Bad debts and associated collection expenses

(m) Employees relocation expenses

(n) Penalties

1. Late Tax
2. Late payment charges. (Note: If a facility can fully document that a late payment charge is directly due to late Medicaid payments, the amount of the late payment charge will be an allowable cost.)
3. Bank overdraft
4. Fines

(o) Certain Real Estate Expenses

1. Appraisals obtained in connection with the sale or lease of an ICF/MR facility (unless required by Medicaid)
2. Costs associated with real estate not related to resident care

(p) Interest Expense

1. Interest associated with real estate in excess of ICF/MR facility needs or real estate not related to resident care.
2. Interest paid to unrelated parties on working capital loans will be limited to no more than 90 days interest on an amount not in excess of two months average allowable cost per cost reporting period
3. Interest expenses applicable to penalties
4. Construction Interest (must be capitalized)
5. Interest paid to a related party
6. Interest on personal property not related to resident care
7. Interest on loans not associated with resident care
8. Interest expense generated by the refinancing of any longterm debt that exceeds the amount which would have been allowed had refinancing not occurred unless such excess interest meets the necessary and reasonableness tests of Rule No. 560-X-42-.08.

(q) Licenses

1. Consultants
2. Professional personnel

(r) Donations and Contributions

(s) Accreditation Surveys

(t) Telephone Services

1. Mobile telephones, beepers, (except for Directors of Nursing or Maintenance personnel), telephone answering and recording devices, telephone call relays, automated dialing services.
2. Long distance telephone calls of a personal nature

(u) Organizational and Start-up Costs - All costs related to the issuance and sale of shares of capital stock, including underwriters' fees and commissions, accounting or legal fees incurred in establishing the business organization, costs of qualifying with the appropriate Federal or State Authorities, stamp taxes, etc., expenses of temporary directors, costs of organizational meetings of directors and/or stockholders and incorporation fees.

(v) Any costs associated with corporate stock records maintenance.

(w) Medicaid administrative fee.

4. Prior Period Costs and Accounts Payable

(a) The Medicaid reimbursement rate is calculated to provide adequate funds to pay business expenses in a timely manner. Costs incurred in prior periods but not paid must be accrued and reported in that period during which the costs were incurred. Payment of prior period cost in the current year is not an allowable cost.

(b) Short-term liabilities must be paid within ninety (90) days from the date of invoice; otherwise, the expense will not be allowed unless the provider can establish to the satisfaction of Medicaid that the payment was not made during 90 days for a valid business reason.

(c) Actual payment must be made by cash or negotiable instrument. For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and must be payable to order of or to bearer. All voided instruments, whether voided in fact or by devise, are considered void from inception.

5. Non-Covered Services

(a) The costs of providing personal services and costs associated with income producing activities are not allowable and must be eliminated from cost. If all costs associated with the service or activity cannot be, or are not identified separately on the cost report, then the total income which was generated must be used to offset total reported costs.

(b) Examples of these services or activities are laundry and dry cleaning of personal apparel (subject to the provisions of Rule 560-X-42-.09, radio, television, telephone, and vending machines).

(c) The following are examples of costs associated with non-covered services or activities which are not reimbursable:

1. Materials or goods
2. Supplies
3. Salaries and Employee Benefits
4. Depreciation, interest, rent, utilities, and insurance on space and equipment

6. Beauty and Barber Services
   (a) If the ICF/MR facility makes no charge to the resident for beauty and barber services, and if this service is performed by employees of the facility or by volunteers, then the costs associated with the service are allowable for Medicaid reimbursement purposes.
   (b) If the ICF/MR facility makes a charge to the resident for beauty and barber services and if all costs associated with the service or activity cannot be, or are not identified separately on the cost report, then the total income which was generated from the service must be used to reduce or offset total reported costs.
7. Miscellaneous or Other Non-Allowable Expenses. The following is a list of expenses which have previously been submitted in cost reports that are unallowable. It is intended to typify unallowable transactions and is not intended to be all-inclusive:
   (a) Nursing consultants, except those required as condition to participation in the ICF program
   (b) Additional wages paid as a result of an audit by the Wage and Hour Administration which relate to a prior period. However, additional payments made as the result of workman's compensation audits conducted after the end of the relevant fiscal year will be considered allowable costs for the fiscal year in which such payments are made
   (c) Newspaper or magazine subscriptions for individual residents
   (d) Off premise telephone service
   (e) Farm expense
   (f) Real estate costs associated with real estate ownership in excess of ICF/MR facility needs and not related to resident care
   (g) Sitter services or private duty nurses
   (h) Cost of meals served to guests and employees
   (i) Fund raising expenses
   (j) Other expenses not appropriate in developing and maintaining adequate resident care facilities
   (k) Any expenses for service or supplies not routinely available to all residents as needed
   (l) Payments to doctors, dentists, etc., for services provided individual residents
8. Gifts. The cost of gifts made by a provider in excess of $20.00 per bona fide facility employee per fiscal year is an unallowable expense.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.20. Cost Reports.

1. Extensions. Each provider is required to file a complete uniform cost report for each fiscal year ending September 30th. The complete uniform cost report must be received by Medicaid on or before November 30th. Should November 30th fall on a state holiday or weekend, the complete uniform cost report will be due the next working day. Cost reports shall be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by ICF/MR facility. Extensions may be granted only upon written approval by Medicaid for good cause shown. An extension request must be in writing, contain the reasons for the extension, and must be made prior to the cost report due date. Only one extension per cost reporting year will be granted by the Agency.

2. Penalties. If a complete uniform cost report is not filed by the due date, or an extension is not requested or granted, the provider shall be charged a penalty of one hundred dollars per day for each calendar day after the due date; this penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting documentation. Once a cost report is late, Medicaid shall suspend payments to the provider until the cost report is received. A cost report that is over ninety (90) days late may result in suspension of the provider from the Medicaid program. Further, the entire amount paid to the provider during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The provider will have thirty (30) days to either refund the overpayment or file the delinquent cost report after which time Medicaid may institute a suit or other action to collect the overpayment amount.
3. Each uniform cost report will be signed by the provider, and if the cost report is prepared by anyone other than the provider or a full-time employee of the provider, such person shall execute the report as the Cost Report Preparer. The signatures of both the provider and Cost Report Preparer, if any, must be preceded by the following certification: I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared on behalf of (Provider name(s) and number(s) for the cost report period beginning and ending , and that to the best of my knowledge and belief, it is a true, correct, and complete report prepared from the books and records of the provider(s) in accordance with applicable Medicaid Reimbursement Principles, except as noted.

Signed

Officer or Administrator

of Provider(s)

Cost Report Preparer

By:

Title

Date Date

4. Any cost report received by Medicaid without the required original signatures and/or without the required certification(s) will be deemed incomplete and returned to the provider.
5. Cost reports will be deemed immutable with respect to the reimbursement for which the provider is entitled for the next succeeding fiscal year, one year from the date of its receipt by Medicaid, or its due date, whichever is later. Providers will have this one year period within which to resubmit their cost reports for the purpose of correcting any material errors or omissions of fact. This one year limitation does not apply to adjustments in cost reports that are initiated by Medicaid. Medicaid retains the right to make adjustments in cost reports at any time a material error or omission of fact is discovered.

6. Providers who terminate their participation in the Medicaid Program, by whatever means, must provide a written notice to the Agency thirty (30) days in advance of such action. Failure to provide this written notice shall result in a one hundred dollar ($100) per day penalty being assessed for each day short of the 30 day advance notice period (up to a maximum of $3,000). Terminating providers must file a final cost report within sixty (60) days of terminating their participation in the program. Final payment will not be made by the Medicaid Agency until this report is received. Failure to file this final cost report will result in Medicaid deeming all payments covered by the cost report period as overpayments until the report is received. Additionally, a penalty of one hundred dollars ($100) will be assessed for each calendar day that the cost report is late. [See Rule No. 560-X-42-.20(2).]
    (a) Terminating cost reports which are audited by the Agency will be subject to retroactive adjustment. This adjustment (if applicable) will either be paid or recouped by a lump sum payment.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988.

Rule No. 560-X-42-.21. Accounting Records.

1. The provider must submit adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be presented on the accrual basis of accounting. This basis requires that revenue must be allocated to the accounting period in which it is earned and expenses must be charged to the period in which they are incurred, regardless of when cash is received or disbursed.
2. Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for supplies, services, or assets. This includes all ledgers, books, records, and original evidence of costs which pertain to the costs reported. Financial and statistical records should be maintained in a consistent manner from one period to another; however, the regard for consistency should not preclude a desirable change in accounting procedures provided that full disclosure of significant changes is made.
3. The following records and documentation must be kept by the provider and must be available for audit inspection by Medicaid:
    (a) General Ledger
    (b) Disbursements Journal
    (c) Cash Receipts Journal
    (d) Payroll Journal
    (e) Working Trial Balance and Adjusting Entries
    (f) Residents Personal Funds Records
    (g) Resident Admission and Discharge records
    (h) Purchases Journal (For facilities larger than 100 beds)
4. Disbursements must be supported by invoices which detail the quantity and price of goods and services purchased, together with evidence that such goods and/or services were received. Disbursements made without proper documentation will not be allowable for Medicaid reimbursement purposes. This documentation should be filed in chronological order, either alphabetically or in some other reasonable manner capable of being audited. Payroll journals must be supported by time cards or other documentation signed by the employee and verified by his/her department head. Each time card or other documentation must also indicate the hours worked by the employee, the rate of pay for the services rendered by the employee, and must be identified by the cost center, to which the expense should be charged. If an employee works in more than one area, the expense should be charged to more than one cost center, and the expenses should be allocated to the centers in the same ratio as the work is performed, with a notation made to explain the allocation.

5. Subsidiary records which must be kept by the provider and be readily available for audit and inspection include, but are not limited to: (items marked by * do not apply to State owned and operated facilities)
   (a) Accounts Receivable ledger sheets or cards which agree with the General Ledger control account (to include September 30 aging schedules).
   (b) Accounts Payable Ledger sheets or cards which agree with the General Ledger control accounts (to include September 30 aging schedules).
   (c) Notes Receivable
   (d) Notes Payable*
   (e) Long-Term Debt evidenced by amortization schedules and copies of the original debt transaction.*
   (f) Insurance policies together with invoices covering the fiscal year reported.
   (g) Depreciation Schedules showing the cost of the facility and equipment. (State owned and operated facilities will provide non consumable property inventory that shows use allowance).
   (h) Payroll Tax Returns*
   (i) Income Tax Returns*
   (j) Census Records (See Schedule 6A)
   (k) Bank Statements, cancelled checks, deposit slips, voided checks, and bank reconciliations
   (l) A signed copy of the current lease*
   (m) Automobile travel logs*
6. Petty Cash Funds shall be maintained under the Imprest System. The disbursement of these funds shall be substantiated by an invoice and/or voucher detailing the date of disbursement, expense category, and name of person disbursing the funds.
7. All documents, work papers, and schedules prepared by or on behalf of the provider which substantiate data in the cost reports must be made available to Medicaid auditors and investigators upon request. These records must be maintained for at least three years, plus the current year, following the date of submission of the relevant cost report.
8. The provider will provide adequate desk space and privacy to Medicaid auditors and investigators during the progress of audits. The provider's personnel or personnel representing an outside independent accountant may be present at a Medicaid audit and be allowed access to the Medicaid auditors and workpapers only at the invitation and discretion of the Medicaid auditors during the course of their work at the provider's establishment.
9. If the provider fails to keep the minimum financial records required to properly substantiate reported costs, the provider will be in violation of the provider agreement and will be subject to termination from the Medicaid program.
10. All books and records required to be kept and made available to Medicaid personnel by a provider will be made available at the ICF/MR facility unless this requirement is specifically waived in writing in advance by Medicaid.
11. If a provider who has been given three (3) full working days notice of an audit fails to make the required records, including any not maintained at the facility, available at that facility, the Medicaid auditor(s) will return to his (their) office, and the provider will be given ten (10) calendar days to present all of the accounting records at the Medicaid office. Should the provider fail to present all of the accounting records at the Medicaid office during the allotted time period, Medicaid will consider all payments made to the provider during the time period covered by the records sought to be audited to be overpayments and may proceed to recover those overpayments from the provider. The provider will also be subject to termination and other sanctions under the Medicaid program.

12. If Medicaid is required to go out of state for an audit, the organization being audited will bear all expenses and costs related to the audit, including, but not limited to, travel and reasonable living expenses, and those costs will not be allowable on any subsequent cost report.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.22. Resident Personal Fund Accounts.

1. Personal Fund Management. In accordance with Federal Regulations for Medicare and Medicaid Facilities, a Medical Assistance resident may manage his personal affairs unless a facility accepts the resident's delegation of this responsibility. A resident managing his personal affairs may voluntarily have a facility hold custody of his funds.
2. Voluntary Resident Delegation of Responsibility to the Facility. There are at least three (3) specific categories of Medical Assistance residents who may voluntarily delegate to the facility the management of personal financial affairs.
   (a) Persons receiving Social Security checks or other income which is applicable under Medical Assistance to the cost of services less a thirty dollar ($30.00) per month personal care allowance.
   (b) Persons receiving a check from the Department of Human Resources for a twenty-three dollar ($23.00) per month personal care allowance.
   (c) Persons receiving donated funds from their family or friends which are not applicable to the cost of services. In the event these persons voluntarily delegate the management or custody of such funds to the facility, proper management and accountability for the funds must be provided by the facility.
3. Establishment of a General Resident Fund Account
   (a) All resident funds for which the facility has accepted delegation or legal responsibility will be maintained in a separate General Resident Fund Account, which may also include the funds of persons who are not under the Medical Assistance Program.
   (b) Receipts, disbursements, and earned interest will be debited and credited to this account. The separate account is required to assure that personal funds of residents are not commingled with other facility accounts and records. Maintenance of the personal fund account is considered to be a normal function of the administrative staff, and no additional personnel will be authorized for reimbursement purposes.
4. Endorsements, Receipts, and Deposits

   The facility shall present checks or other receipts for moneys to the resident for his personal endorsement prior to depositing them in the facility's General Resident Fund Account. If funds received by the facility do not require endorsement, the facility will insure that all such funds are properly posted in the individual Resident Subsidiary Ledger. Unless prior written authorization is given by the resident or his/her guardian, a voucher or other form of documentation showing the date, amount, and proper authorizing signature for each transaction shall be retained by the facility.
5. Expenditure of Funds from the General Resident Fund Account
   (a) A facility may not use a Medicaid resident's personal funds to supplement a payment for nursing care. A facility that fails to comply with this regulation will be subject to prosecution under Federal and State laws.
   (b) Also, a facility may not bill a resident for undelivered personal services such as manicures, haircuts, hair styling, laundry, and dry cleaning.
   (c) The resident or his/her sponsor must have freedom of choice in determining the purpose for which the resident's personal funds will be spent.
   (d) Within thirty (30) days after discharge or transfer of the resident to another facility, all remaining funds for the resident shall be returned by check to the resident or the resident's legally responsible relative or legal guardian.

(e) In case of death, all remaining funds shall be returned by check to the resident's estate.

6. Accounting Records to be Maintained. A facility shall maintain the following records relative to the receipt and expenditure of a Medicaid resident's funds.

   (a) General Resident Fund Account

      1. The facility shall maintain a separate accounting record for the General Resident Fund Account. This accounting record may be maintained in the General Ledger. The total of all resident's funds shall be reflected in this account, except funds transferred to a savings account.
      2. The total resident's funds record shall be reconciled to the bank statement each month.

   (b) Individual Resident Subsidiary Ledger

      1. An Individual Resident Ledger, which may be a card or computer record, shall be maintained for each Medicaid resident for whom the facility has accepted the responsibility for personal funds. If a computer record is maintained, a quarterly printout is required and should include the same information as is required on the card.
      2. The Medicaid resident's full name and Medicaid number are to be entered on the form. All deposits and disbursements are to be recorded in chronological order.

   (c) General Ledger Savings Account of Total Resident Funds

      1. The facility must deposit in a Federally insured savings account all funds in excess of $50.00 per resident.
      2. An account of the total amount of resident's funds deposited in a savings account is to be maintained by the facility.
      3. The facility may not use interest earned on resident funds to meet the costs of maintaining the resident funds.
      4. Interest earned must be appropriately apportioned to each members account balance during the period involved.

   (d) Petty Cash Fund Records

      1. Facilities that maintain a petty cash fund to disburse small amounts of money to residents shall credit the total withdrawal of such funds to the General Resident Fund Account described previously.
      2. When the Petty Cash Fund is replenished, the amounts of the disbursements shall be posted to the Individual Resident Subsidiary Ledger.

   (e) Inadequate Records when individual resident subsidiary ledgers or records do not reconcile with the Resident Personal Fund Bank Accounts and/or control account, the resident's funds are commingled with facility funds, or when any other situation exists in which auditors are unable to determine correct balances and/or separation of the resident personal funds, an income offset adjustment for any difference shall be made against other allowable reported costs of the provider. The adjustment (if any) will be determined during the course of an audit in accordance with generally accepted accounting principles and auditing standards.

7. Reporting of Resident's Funds Quarterly Report to resident. In accordance with Federal regulations, at least once every three (3) months, the facility will give the resident, or the resident's legally responsible relative or legal guardian, a copy of the Individual Subsidiary Resident Ledger Card or computer printout listing all deposits, disbursements, and the current balance.

8. Assurance of Financial Security. The facility must purchase a surety bond to assure the security of all personal funds of residents deposited with the facility.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.23. Audit Adjustment Procedures.

1. Audit adjustments will be paid or collected by a combination of (1) changing the per diem rate of the facility and (2) a lump sum settlement for the amount under/over paid for the period prior to the effective date of the per diem rate change.
2. Under/Overpayment situations arising from the audit of a terminating cost report will be paid or recouped by a lump sum settlement.
3. All adjustments will be subject to the limitations set out in this Chapter and subject to the appropriate ceilings.
4. Collection procedures will be applied only after the facility has been given thirty (30) days in which to disagree with any of the disallowances contained in the report of audit.
5. A copy of the report of audit will be forwarded to the Reimbursement and Rate Analysis Section when the report of audit is mailed to the facility. After the thirty (30) day notification period is up and no request for an informal conference has been received, a new per diem rate will be calculated based on audit adjustments in the report of audit. The new per diem rate will be effective for billing purposes on the 1st day of the following month. A final audit computation sheet will be prepared. The audit settlement will be collected or paid in a lump sum amount. This lump sum amount for the months prior to the effective date of the rate change is computed by applying the adjustment per resident day to the total Medicaid days in the overpayment/underpayment period.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.24. Appeals.

1. Facility administrators who disagree with the findings of the Medicaid desk audits or field audits may request, in writing, an informal conference at which they may present their positions. Such written requests must be received by Medicaid within thirty (30) days of the date on which Medicaid mails the audit report, or new reimbursement rate, as the case may be, to the provider.
2. Administrators who believe that the results of the informal conference are adverse to their facility may ask, in writing, for a Fair Hearing, which will be conducted in accordance with Medicaid Regulations. Such written requests must be received by Medicaid within fifteen (15) days of the date on which Medicaid mails to the provider its determination on the issues presented at the informal conference.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.25. Negligence Penalty.

1. Whenever an overpayment of Medicaid reimbursement received by a provider from Medicaid results from the negligence or intentional disregard of Medicaid Reimbursement Principles by the provider or its representatives (but without intent to defraud), there will be deducted from any reimbursement thereafter due the provider a penalty equal to 5% of such overpayment.
2. If any part of such an overpayment by Medicaid to the provider is due to fraud on the part of the provider or any of its representatives, there will be deducted from any subsequent reimbursement due the provider on proof of fraud, a penalty equal to 50% of the overpayment.
3. The penalties imposed under Rule No. 560-X-42-.25 of this Code shall be in addition to and shall in no way affect Medicaid's right to also recover the entire amount of the overpayment caused by the provider's or its representative's negligence or intentional disregard of the Medicaid Reimbursement Principles or fraud.
4. Whenever the cost of a good or service has been previously disallowed as the result of a desk audit of a provider's cost report and/or a field audit by Medicaid and such cost has not been reinstated by

voluntary action of Medicaid, as the result of an administrative hearing, or by a Court, such costs shall not thereafter be included as an allowable cost on a Medicaid cost report. The inclusion by the provider or its representative of such a cost on a subsequent cost report, unless the provider is actively pursuing an administrative or judicial review of such disallowance, will be considered as negligent and/or intentional disregard of the Medicaid Reimbursement Principles and subject to the 5% penalty imposed by Rule No. 560-X-42-.25(.02) of this Code based upon the amount of overpayment which has or which would have resulted from the inclusion of such cost had its inclusion not been detected. Such inclusion shall also be subject to the provisions of Rule No. 560-X-42-.25(.02) relating to intentional or negligent disregard of the Medicaid Reimbursement Principles.

5. For purposes of the preceding paragraph, a provider shall be considered as having included a previously disallowed cost on a subsequent year's cost report if the cost included is attributable to the same type good or service under substantially the same circumstances as that which resulted in the previous disallowance. Examples of such prohibited inclusions include, but are not limited to:
   - (a) Inclusion of the portion of rental payment previously disallowed as being between related parties.
   - (b) Inclusion of an amount of compensation which has previously been disallowed as unreasonable during a prior period.
   - (c) Inclusion of a cost not related to resident care which has previously been disallowed.
   - (d) Improper classification or allocation of costs to cost centers.
6. Rule No. 560-X-42-.25 shall NOT be interpreted as indicating that a provider's or his representative's initial entry of a cost item on a cost report will not be treated as a negligent or intentional disregard of the Medicaid Reimbursement Principles.
7. Any provider who knowingly files or allows to be filed a cost report which has been prepared by a person who has been suspended as a Cost Report Preparer during his period of suspension, shall be subject to termination of its provider agreement, and, in addition, subsequent reimbursement otherwise due the provider shall be reduced by a $1400.00 penalty.
8. Providers and their representatives who are uncertain as to whether the inclusion of a cost in a cost report is in violation of the Medicaid Reimbursement Principles should footnote or otherwise call attention to the entry in question and specifically disclose the dollar amount and the portion of the cost report entry as to which they are in doubt.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

Rule No. 560-X-42-.26. Cost Report Preparers.

1. Cost Report Preparers. "Cost Report Preparer" includes any person (including a partnership or corporation) who, in return for compensation, prepares or employs another to prepare all or a substantial portion of a Medicaid cost report. A Cost Report Preparer can include both the actual preparer of the report as well as his or her employer. Where more than one person aids in filling out a Medicaid cost report, the one who has primary responsibility for the preparation of the report will usually be a preparer, while those involved only with individual portions of the report will usually not be preparers. Any person who supplies enough information and advice so that the actual completion of the return is a mere mechanical or clerical matter is a Cost Report Preparer even though the person doesn't actually place or review the placement of the information on the cost report.
2. Refusal of Cost Reports. Medicaid will refuse to accept cost reports prepared by a Cost Report Preparer who:
   - (a) Has shown a pattern of negligent disregard of the principles established by or incorporated by reference into this Code;
   - (b) Prepares a cost report evidencing an intentional disregard of the Medicaid Reimbursement Principles;
   - (c) Has given false or misleading information, or participated in giving false or misleading information to any Medicaid employee, the Alabama Medicaid Agency, or to any hearing

officer authorized to conduct hearings with regard to Medicaid reimbursement issues, knowing such information to be false or misleading. "Information" includes facts or other information contained in testimony, Medicaid Cost Reports, financial statements, affidavits, declarations, or any other documents or statements, written or oral.

(d) Medicaid will treat any cost report prepared by a Cost Report Preparer who has been determined to be ineligible to prepare Medicaid cost reports as incomplete and shall promptly return any such Cost Report to the provider on whose behalf the report has been prepared. The receipt by Medicaid of such cost reports shall not satisfy, suspend, or stay the requirements of this Chapter relating to the timely filing of Medicaid Cost Reports.

3. Determination of Eligibility.

(a) Upon receipt by any Medicaid employee of information indicating that a Cost Report Preparer may have engaged in conduct which could result in the refusal by Medicaid to accept cost reports prepared by such preparer under Rule No. 560-X-42-.26 of this Section, such information shall be promptly reported to Medicaid's Chief Auditor who shall insure that an informal inquiry is made regarding the reliability of such information. Medicaid legal counsel and/or appropriate representatives of the Attorney General's office shall be consulted, as deemed appropriate.

(b) Informal Inquiry.

1. If the Chief Auditor, based upon such informal inquiry, determines that there is substantial evidence that the preparer has engaged in conduct specified in Rule 560-X-42-.25, he/she will give written notice to the preparer which will offer the preparer the opportunity to refute such information or allegations. If the preparer fails to provide the Chief Auditor with information which results in a determination by the Chief Auditor that the evidence of misconduct is insufficient to justify suspension, the Chief Auditor will, at the preparer's request, have a hearing arranged and will have the preparer notified that such an administrative hearing will be held with regard to the alleged misconduct.

2. Should the preparer fail to deny or provide documentation or information to refute the allegations made against him within thirty (30) days after the date of the mailing of the initial letter to the preparer, such allegations will be deemed to be admitted, and the preparer will have waived his right of hearing. The Chief Auditor will then notify the preparer of his suspension under this rule.

3. The above-described hearing will be set for a time no earlier than thirty (30) days after the date of the mailing of the initial letter to the preparer.

(c) Procedures Related to Informal Inquiry and Hearing.

1. Notice. The initial notice from the Chief Auditor to the preparer will describe with sufficient specificity the allegations being made against him to allow him to respond to those allegations in a specific manner.

2. The Notice of Hearing. The notice of hearing to the preparer will repeat the allegations which constitute the basis for the proceedings and state the date, time, and place of the hearing. The hearing, as noted in Rule No. 560-X-42-.26(3)(b)(1) above will be arranged only at the request of the preparer. Such notice shall be considered sufficient if it fairly informs the preparer of the allegations against him so that he is able to prepare his defense. Such notice may be mailed to the preparer by first class or certified mail, addressed to him at his last address known to the Chief Auditor. A response or correspondence from the preparer or his representative shall be mailed to Chief Auditor, Alabama Medicaid Agency.

3. Answer. No written answer to the notice of hearing shall be required of the preparer.

4. Hearing. The hearing shall be conducted in accordance with Medicaid's Regulations (Chapter 3 of the Alabama Medicaid Administrative Code) related to Fair Hearings.

5. Failure to Appear. If the preparer fails to appear at the hearing after notice of the hearing has been sent to him, he shall have waived the right to be present. The hearing officer may proceed with the conduct of the hearing and make his/her recommendation to the Commissioner of Medicaid who may make his or her determination.
6. Determination of Ineligibility. The determination of the ineligibility of a Cost Report Preparer to prepare Medicaid cost reports will lie solely with the Commissioner of Medicaid. The Commissioner will make such determination after giving due consideration to the written recommendation of the Hearing Officer.
7. Notification of Ineligibility. If the determination of the Commissioner is that the preparer shall no longer be eligible to prepare Medicaid cost reports, the preparer shall be notified in writing, and the preparer shall thereafter not be eligible to prepare such reports unless and until authorized by the Commissioner of Medicaid to do so. Such a preparer shall IN NO EVENT be eligible to prepare such cost reports during the two (2) year period immediately following his suspension. Any person who acts as a Cost Report Preparer during his period of suspension shall not thereafter be eligible to act as a Cost Report Preparer for a period of ten (10) years from the date of his original suspension. Any provider who knowingly allows a cost report to be prepared by a person who has been suspended under this Section will be subject to having its provider agreement cancelled and will be subject to the applicable penalties of Rule No. 560-X-42-.25 of this Code.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.250-.255. Rule effective October 13, 1988. Effective date of this amendment July 13, 1993.

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Chapter 43. Prenatal Services

Rule No. 560-X-43-.01. General.

1. Prenatal care services are those services that are necessary for the health of the pregnant woman and her fetus during the antepartum period.
2. Prenatal services, including initial and periodic evaluation of patient's status, are covered for the entire gestational period.
3. Prenatal services are available through providers who are under contract with the Alabama Medicaid Agency, including Primary Care Clinics, Rural Health Clinics, FQHC's, the Department of Public Health Clinics, physicians, and nurse midwives.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Sections 440.165, 440.50, 440.90, 440.130, and 440.210. Rule effective August 10, 1988. Effective date of this amendment June 14, 1994.

Rule No. 560-X-43-.02. Eligibility.

Persons eligible for prenatal services are those Medicaid eligible persons deemed pregnant by laboratory tests or physical examination, without regard to marital status.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Sections 435.1 and 435.110. Rule effective August 10, 1988. Effective date of this amendment June 14, 1994.

Rule No. 560-X-43-.03. Consent for Services.

1. The Code of Alabama, 1975, Title 22, Chapter 8, governs the rights of minors to consent to any legally authorized medical service.
2. Illiterate recipients may give consent for prenatal services by making their mark (i.e., "X") on the appropriate line. This type of consent for services must be witnessed by an adult with his/her signature after the phrase "witnessed by."
3. A patient's acceptance of any prenatal service or information is strictly voluntary on the part of the patient. The provider must not administer any form of duress or coercion to gain such acceptance.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 431.51. Rule effective August 10, 1988. This amendment effective June 14, 1994.

Rule No. 560-X-43-.04. Covered Services.

1. Antepartum Care:
   - (a) Antepartum care includes all usual prenatal services such as the initial office visit, at which time pregnancy is diagnosed, and subsequent visits that include histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling and risk assessments. Antepartum care also includes routine lab work (i.e., hematocrit and chemical urinalysis); therefore, claims for routine lab work should not be filed.
   - (b) The frequency of return visits should be determined by the risk assessment. For an uncomplicated pregnancy the subsequent visits are to follow the recommendations listed in the Standards for Obstetrical/Gynecological Services, published by the American College of Obstetricians and Gynecologists.
   - (c) If appropriate, patients with high risk pregnancies shall be referred to a qualified physician for evaluation and management of the pregnancy.
   - (d) Laboratory services as appropriate for quality prenatal care as recommended by the American College of Obstetricians and Gynecologists are covered.
2. Post partum care:
   - (a) Post partum care includes visits following delivery for routine post partum care within sixty (60) days past delivery. Additional claims for routine visits during this time are not covered.

1. One (1) post partum office visit [six(6)-week checkup] is authorized for completion of the maternity cycle.
2. Two (2) additional post partum visits are authorized for post partum patients with obstetrical complications; e.g., infection of surgical wound, during the 60-day post partum period. Medical records should clearly document the complication requiring the additional visit.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Sections 440.30, 440.50, 440.90 and 441.16. Rule effective August 10, 1988. Rule amended November 13, 1991. Effective date of this amendment June 14, 1994.

Rule No. 560-X-43-.05. Billing of Medicaid Recipients.

1. A provider may bill Medicaid recipients for any noncovered procedure or service provided to a recipient who has exhausted her annual benefits.
2. Billing of recipients for services not paid by Medicaid due to provider correctable errors on claim submissions or untimely filing is not permissable.
3. Medicaid recipients are exempt from co-pay requirements for prenatal services.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., Section 447.15, Att. 4.18A. Rule effective June 14, 1994.

Rule No. 560-X-43-.06. Prenatal Program Manual.

1. A Prenatal Program Manual detailing the elements of the antepartum visits, instructions for completion of forms, and procedures to follow in the administration of services is provided to the prenatal providers.
2. Prenatal providers will be required to follow procedures outlined in the manual. Failure to do so may result in the recoupment of paid claims from provider.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R., 401, et seq. Rule effective June 14, 1994.

Chapter 44. Quality Assurance

Rule No. 560-X-44-.01. Quality Assurance – General.

1. The Alabama Medicaid Agency has designated the Quality Assurance (QA) Program responsible for utilization management for hospital inpatient services including performance measurement and oversight under the provisions of the Code of Alabama, 1975, Section 41-16-20 through 41-16-27, as amended, and Section 41-22-1, et seq. This function is also in direct compliance with 42 C.F.R. Section 456.50 - Section 456.145 (Subpart C).
2. Certification of Need for Care - A physician must certify in the medical records that inpatient hospital services are needed by a recipient. This certification must be made at the time of admission or, if an individual applies for Medicaid eligibility while in the hospital, before the Alabama Medicaid Agency (Medicaid) authorizes payment.
3. Plan of Care - Before admission to the hospital or before authorization for payment by Medicaid for an individual applying for Medicaid eligibility while in the hospital, a physician and/or other personnel involved in the care of the individual must establish a written plan of care for the recipient. This plan must meet the requirements set forth in 42 C.F.R. Section 456.80.
4. Utilization Review (UR) Plan - For the purpose of utilization review of inpatient services, a hospital provider shall be designated by Medicaid as either delegated or non- delegated.
   (a) Delegated Hospital - A hospital which has been designated by Medicaid as a delegated hospital shall:
      1. Have in effect a written UR Plan that provides for review of each recipient's need for the services that the hospital furnishes.
      2. This written UR Plan must meet the requirements under 42 C.F.R. Section 456.101 through 456.145.
      3. The recipient information required for UR under 42 C.F.R. Section 456.111 shall include the physician certification of need for care.
      4. The medical care criteria required by 42 C.F.R. Section 456.122 and Section 456.128 shall be provided to the hospital by Medicaid or its designee.
      5. A copy of the UR Plan and any subsequent revisions shall be provided to Medicaid or its designee for review.
   (b) Non-Delegated Hospital - For a hospital, which has been designated by Medicaid as non-delegated, prior authorization for Medicaid admissions and continued stays shall be accomplished by Medicaid or its designee. The Medicaid Quality Assurance Program will perform the utilization review function until which time the Agency deems the hospital or its designee capable of effectively performing utilization review functions in accordance with 42 C.F.R. Section 456.101 through 456.145.
5. If a hospital has a change of ownership, it is the responsibility of the new owners to provide Medicaid with a copy of the UR Plan.
6. Managed Care initatives are detailed in the Managed Care Chapter. Refer to the Managed Care Chapter for contractor and subcontractor responsibilities in each program.

Authority: State Plan; 42 C.F.R. Part 456 Subpart C; Section 1902 (d) Title XIX, Social Security Act. Rule effective October 12, 1988. Emergency Rule effective October 1, 1996.

Effective date of this amendment January 14, 1997.

Rule No. 560-X-44-.02. Definitions.

The following terms and definitions are presented to clarify the rules contained in this chapter of the Alabama Medicaid Administrative Code.

1. Admission Review - A review and determination of the medical necessity and appropriateness of an admission to a hospital.
2. Admission Certification - Documentation in the medical record by a physician that inpatient hospital services are or were needed.
3. Alabama Medicaid Adult and Pediatric Inpatient Care Criteria - Criteria developed by Medicaid to evaluate the medical necessity and appropriateness of a hospital stay.
4. Continued Stay Review - A review of the medical necessity and appropriateness of continuing the patient's in- patient hospital stay.
5. Delegated Hospital - A hospital to which utilization review functions are delegated by the State, based upon an assessment of the capability of a hospital to effectively perform review functions.
6. Denial - A formal decision that all or part of a patient's hospital stay or proposed stay is medically unnecessary for the purpose of reimbursement.
7. Denial Letter - A written notice of adverse initial determination to the recipient, the attending physician, the provider and the Medicaid Agency.
8. Discharge Indicators - Specific indicators of a patient's stability.
9. Elective Admission - An admission or service that can be delayed without substantial risk to the health of the individual.
10. Emergency Admission - An unexpected medical condition that cannot be delayed without substantial risk to the health of the individual.
11. Medical Necessity - The need or condition documented in the medical record by a physician which indicates the level of care required.
12. Medical Care Evaluation Study - An assessment, performed retrospectively, of the quality or nature of the utilization of health care services.
13. Non-Delegated Hospital - A hospital for which review functions are performed by the Medicaid Agency or designee on a temporary basis as deemed appropriate and until the Agency determines the hospital or its designee can effectively perform review functions.
14. Out-Of-State Participating Hospital - A hospital located within thirty miles from the Alabama state line which has executed a provider agreement with the Alabama Medicaid Agency. Out-of-state participating hospitals are required to maintain utilization management requirements as specified through contractual agreement with the Agency.
15. On-Site Review - On-site visits to hospitals are made as deemed necessary.
16. Physician Advisor - A physician who evaluates performance, quality, outcome, and determines medical necessity in cases not meeting screening criteria and/or referred by the review coordinator.
17. Pre-Admission Review - A review and determination prior to a patient's admission to a hospital of the medical necessity and appropriateness of an elective health care service.
18. Prior Authorization Number - A six-digit number issued to non-delegated hospitals for approved admissions. This number is required for claim processing.
19. Quality Assurance - A function designed to facilitate the evaluation of performance awareness, performance measurement, and performance improvement.
20. Reconsideration - A recipient or provider dissatisfied with an adverse initial determination is entitled to have the determination reconsidered.
21. Recoupment - Reimbursement of an overpayment received from the Medicaid program by a provider.

22. Retrospective Review - Admissions reviewed and approved prior to the recipient being assigned a Medicaid number. For example, upon the hospital obtaining knowledge of application for Medicaid benefits.
23. Retrospective Sampling - A representative sampling of aggregate Medicaid admissions are reviewed retrospectively on a quarterly basis for validation of performance, quality, outcome, oversight, and medical necessity of hospitalizations.
24. Review Coordinator - The person designated as responsible for timely review of Medicaid admissions by utilizing the Inpatient Care criteria and other approved measurement tools (e.g.: established clinical pathways).
25. Utilization Review (UR) - A procedure to ensure that services provided are commensurate with the patient's medical condition. This includes reviewing quality of care, scope of services, medical necessity, and outcome determinations.
26. Utilization Review Committee (URC) - A committee composed of two or more physicians and assisted by other professional personnel within the delegated hospitals.
27. Utilization Review Plan - A written UR Plan that provides for review of each recipient's need for the services that the hospital furnishes. Each hospital furnishing inpatient services must have in effect a written UR Plan.

Authority: State Plan; 42 C.F.R. Section 401, et seq. Rule effective October 12, 1988. Amended August 12, 1995. Emergency Rule effective October 1, 1996. Effective date of this amendment January 14, 1997.

Rule No. 560-X-44-.03. Delegated Hospital Review.

1. Admission Review - Hospitals which have been designated as "Delegated" by Medicaid will designate a UR Committee to perform admission reviews, and continued stay reviews.
    - (a) Admission reviews will be performed by the UR committee or a designee of the committee within one (1) working day of the admission. Friday, Saturday, and holiday admissions will be reviewed the following work day.
    - (b) The medical care evaluation criteria to be used will be the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria.
    - (c) If the review coordinator determines that the admission is appropriate, the admission is approved and a continued stay review date is assigned, not to exceed 72 hours.
    - (d) Admissions which are not deemed appropriate are referred to the physician advisor. If the physician advisor finds that the admission is not warranted, the recipient's attending physician will be notified and given the opportunity to submit additional information. If the attending physician does not present additional information the decision of the physician advisor will stand. If the attending physician does present additional information, at least two (2) physician members of the UR Committee will review the need for admission. If they find that the admission is not needed, the decision is final.
    - (e) If a denial determination is made, the review coordinator will notify the patient, the attending physician, and Medicaid in writing. The denial letter will be issued within two working days of the determination. Medicaid will be notified in writing within ten (10) days after the determination is made.

2. Continued Stay Review - Continued stay review will be performed by a designee of the hospital's UR Committee. In no event shall the continued stay review date exceed 72 hours after completion of the admission review process.
   (a) Cases which do not meet the criteria will be referred to the physician advisor.
   (b) If the physician finds that the continued stay is not needed, the recipient's attending physician will be notified and given the opportunity to submit additional information. If the attending physician does not present additional information the decision of the physician advisor will stand. If the attending physician does present additional information, at least two physician members of the UR Committee will review the need for continued stay. If they find that the continued stay is unnecessary, the decision is final.
   (c) If a denial determination is made, the review coordinator will notify the patient, and the attending physician within two days of the determination. Medicaid will be notified in writing within ten (10) days after the determination is made.
3. Surgical Procedures - Surgical procedures should be scheduled to be performed the day of admission. Medical records must contain sufficient documentation to warrant early admission to the hospital for any surgical procedure scheduled to be performed after the admission date. This documentation must indicate a medical condition that would justify the prolonged hospital stay. QA personnel will review these admissions retrospectively. If no justification for the early admission is indicated in the medical records, QA will recommend recoupment of the days prior to the surgery.
4. Retrospective Admissions and Continued Stay Reviews
   (a) A representative sample of Medicaid admissions will be reviewed quarterly by QA personnel utilizing the Inpatient Care criteria and other approved measurement tools for admissions and continued stays.
   (b) If it appears that any of the approved admissions do not meet the Inpatient Care criteria QA staff will contact the entity's review coordinator to request additional admission documentation.
   (c) If no additional information is provided or if the information fails to support the admission, Medicaid will seek recoupment of the improperly documented admissions.
   (d) The hospital/entity will be notified in writing
   (e) of the identified recoupment and allowed fifteen days from receipt of the letter to respond prior to the initiation of the recoupment process.
   (f) QA will work with hospitals to alleviate persistent problems with improperly documented admissions. If these efforts fail, QA will recommend that the hospital be re-designated as non-delegated.
5. Discharge Indicators - Discharge indicators listed in the Inpatient Care criteria will be applied during discharge analysis. If the discharge indicators are met, the patient should be discharged within 24 hours. If the discharge indicators are met and discharge is not scheduled, the case will be referred to the physician advisor for review. If the patient is not discharged, a denial notification letter will be issued.
6. Delegated Hospital's On-Site Review - Medicaid's QA staff will conduct on-site reviews of Medicaid admissions and continued stays as deemed necessary. The hospital will be notified in advance of the medical records to be reviewed during the on-site visit.

Authority: State Plan; 42 C.F.R. 456 Subpart C; Section 1902 (d) Title XIX, Social Security Act. Rule effective October 12, 1988. Amended August 12, 1995. Emergency Rule effective October 1, 1996. Effective date of this amendment January 14, 1997.

Rule No. 560-X-44-.04. Non-Delegated Hospital Review.

1. Admission Review - Hospitals which have been designated as "Non-Delegated" by Medicaid will provide information to Medicaid's QA Program for 100 percent of all admissions and continued stays. The hospital will designate an individual who will act as contact person for that hospital. This person will be responsible for conveying all information needed for review to QA personnel.
   - (a) All Medicaid admissions for individuals eligible for Medicaid at the time of admission will be called in to QA personnel for review within one working day of admission
   - (b) with the exception of Friday, Saturday, and holidays. Admissions on these days will be called in for review on the following work day.
   - (c) Admissions will be called in for review within one (1) working day after the hospital is notified of the application for Medicaid for an individual who applied while in the hospital.
   - (d) A six-digit prior authorization number will be issued to non-delegated hospitals for all approved admissions that meet the Inpatient Care criteria. This number is required for claims processing.
   - (e) Admissions not called in to the QA Program within one working day of the admission will be approved beginning at the time the review is called to the QA Program, if Inpatient Care criteria for admission is met.
   - (f) QA review coordinators will use the Alabama Medicaid Adult and Pediatric Inpatient Care criteria to determine medical necessity. Any questionable cases will be referred to the physician advisor.
   - (g) If the physician advisor finds that the admission does not meet the Inpatient Care criteria, the recipient's attending physician will be notified by the hospital's review coordinator and given the opportunity to submit additional information. If the attending physician does present additional information, another physician advisor will review the need for admission. If he agrees that the admission does not meet the Inpatient Care criteria, the decision is final.
   - (h) If a denial determination is made, QA will notify the patient, the attending physician and administrator in writing.
2. Continued Stay Review - The continued stay review date shall be scheduled by an QA review coordinator within 72 hours of the completion of the admission review process to determine the continuing status of the patient. Certain categories of admissions may be assigned a continued stay review which exceeds 72 hours.
   - (a) QA personnel will perform continued stay reviews.
   - (b) Hospital personnel will provide information, which will be compared to the Inpatient Care criteria for determination of need for continued stay.
   - (c) Continued stay reviews not called on the assigned continued stay review date will be approved beginning on the date the review is called to the QA Program if the Inpatient Care criteria for continued stay is met. These stays must be split billed to separate the authorized days from non-authorized days. QA will issue two prior authorization numbers for claim processing.
   - (d) Discharge Indicators listed in the Inpatient Care criteria will be applied during discharge analysis. If the discharge indicators are met, the patient should be scheduled for discharge within 24 hours. If the discharge indicators are met and discharge is not scheduled, the case will be referred to the physician advisor for review. If the patient is not discharged a denial notification letter will be issued.
3. Surgical Procedures - Surgical procedures should be scheduled to be performed the day of admission. Medical records must contain sufficient documentation to warrant early admission to the hospital for any surgical procedure scheduled to be performed after the admission day. Medicaid's QA staff will use Inpatient Care criteria to determine medical necessity. Any questionable cases will be referred to the staff physician.

Authority: State Plan; 42 C.F.R. Section 456 Subpart C; Section 1902 (d) Title XIX, Social Security Act. Rule effective October 12, 1988. Amended August 12, 1995. Emergency Rule effective October 1, 1996. Effective date of this amendment January 14, 1997.

Rule No. 560-X-44-.05. Reconsiderations For Non-Delegated Hospitals.

1. If an adverse determination is made by QA personnel on an admission or continued stay in a non-delegated hospital,
2. the patient, the attending physician, or the hospital may request a reconsideration of the decision.
3. The request for a reconsideration must be submitted in writing within thirty (30) days after the adverse determination is made to the Quality Assurance Program at the Alabama Medicaid Agency.
4. All applicable medical records must be submitted with the reconsideration request.
5. If the hospital or physician is requesting the reconsideration, medical records may be forwarded along with the request to expedite the reconsideration process.
6. If the Agency's physician advisor finds that the admission or continued stay does meet the Inpatient Care criteria, the patient, attending physician and hospital will be notified that the stay is approved.
7. If the Agency's physician advisor finds that the admission or continued stay does not meet the Inpatient Care criteria, a second physician will review the medical record. If the second physician agrees that the admission or continued stay does not meet the Inpatient Care criteria the decision is final.
8. If an adverse determination of a reconsideration is made, the patient, attending physician, or hospital may request a fair hearing.

Authority: State Plan; 42 C.F.R. Section 401, et seq. Rule effective October 12, 1988. Amended August 12, 1995. Emergency Rule effective October 1, 1996. Effective date of this amendment January 14, 1997.

Rule No. 560-X-44-.06. Extended Hospital Days for Delivery.

1. Additional inpatient days for delivery may be authorized for recipients who have exhausted their yearly limitation.
2. All delegated and non-delegated hospitals will contact QA personnel for authorization of these deliveries.
3. Only inpatient days for delivery after the yearly benefit limitation has been exhausted will be considered for additional benefit days.
4. Requests for authorization should not be made prior to delivery. A six-digit authorization number for the approved stays will be issued by QA personnel.
5. Claims for extended benefit days should be filed separately from all other inpatient stays. This will require split billing.

Authority: State Plan; Title XIX, C.F.R. 456 Subpart C. Rule effective October 12, 1988. Amended August 12, 1995. Emergency Rule effective October 1, 1996. Effective date of this amendment January 14, 1997.

Rule No. 560-X-44-.07. Fair Hearings.

Refer to the Fair Hearings Chapter for details.

Authority: State Plan; Title XIX of the Social Security Act 42 C.F.R. Section 401 et seq. Rule effective October 12, 1988.

Rule No. 560-X-44-.08. Billing and Sending Statements to Eligible Alabama Medicaid Recipients.

1. No eligible Alabama Medicaid recipient is to receive a bill or statement for covered services or items once that recipient has been accepted as a Medicaid patient, except for the appropriate allowable co-payment amount.
2. It is the responsibility of the provider to follow up with the fiscal agent and/or Medicaid, and not the recipient, on any problem or unpaid claim.
3. Providers may bill eligible recipients for non-covered services; i.e., excessive days beyond benefit limitations, private room accommodation charges incurred due to patient's request, personal comfort items. See Rule No. 560-X-7-.15.
4. Medicaid recipients in delegated and non-delegated hospitals may be billed for inpatient care following the receipt of written notification of non-coverage of hospital services . If the notice is issued prior to the admission the recipient will be liable for full payment if he enters the hospital. If the notice is issued at or after admission, the recipient will be responsible for payment for all services provided after receipt of the notice.
5. Medicaid recipients may not be billed for inpatient stays in delegated hospitals that were initially approved by the hospital's utilization review committee in the event that the Medicaid Agency determines during the retrospective review
6. that the admission did not meet the Inpatient Care criteria.
7. Medicaid recipients may not be billed for inpatient care provided by non-delegated hospitals solely because the hospital failed to obtain the required admission and continued stay authorization.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 447.15, 447.50, and 447.55. Rule effective October 12, 1988. Effective date of this amendment August 12, 1995.

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Chapter 45. Maternity Care Program

Rule No. 560-X-45-.01 Authority and Purpose.

(1) Pregnancy related care for Medicaid eligible women provided through the Maternity Care Program (MCP) is provided pursuant to the Alabama State Plan as approved by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) and the approved 1915(b) Waiver. The purpose of the program is to provide a comprehensive, coordinated system of obstetrical care to pregnant recipients.

(2) Coverage for the MCP includes the provisions of the Balanced Budget Act of 1997 and the subparts of the BBA Medicaid Managed Care regulation at 42 CFR Part 438.

(3) Program specifics are delineated in the Invitation to Bid (ITB) that is utilized for selection of Primary Contractors for the program.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.02 Eligibility.

(1) Pregnant women participating in the program are determined Medicaid eligible by Medicaid and/or other approved certifying agencies through the normal eligibility process. Persons eligible for the MCP are women deemed pregnant through medical examination and/or laboratory tests.

(2) Recipients eligible for both Medicare and Medicaid shall not be enrolled.

(3) Providers shall access eligibility information through the Medicaid Automated Voice Response System or the appropriate electronic software for specific information on the county of residence and the pregnancy restriction to a Primary Contractor.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.03 Primary Contractor Standards.

Primary Contractors must comply with the provisions of the executed contract, its amendments and referenced materials, the approved 1915(b) Waiver, and all other state and federal regulations governing the Medicaid program. The following outlines the standards for the Primary Contractor.

(1) Demonstrate the capability to serve all of the pregnant Medicaid eligible population in the designated geographical area.

(2) Designate a Director or other designee to be available, accessible, and/or on call at all times for any administrative and/or or medical problems which may arise.

(3) Require subcontractors providing direct care to be on call or make provisions for medical problems 24-hours per day, seven days per week.

(4) Require that all persons including employees, agents, subcontractors acting for or on behalf of the Primary Contractor, be properly licensed under applicable state laws and/or regulations.

(5) Comply with certification and licensing laws and regulations applicable to the Primary Contractor's practice, profession or business. The Primary Contractor agrees to perform services consistent with the customary standards of practice and ethics in the profession. The Primary Contractor agrees not to knowingly employ or subcontract with any health professional whose participation in the Medicaid and/or Medicare Program is currently suspended or has been terminated by Medicaid and/or Medicare.

(6) Require that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider only serves Medicaid recipients as required at 42 CFR 438.206(c)(1)(i).

(7) Establish mechanisms to ensure that the network providers comply with timely access requirements. The primary contractor shall monitor regularly to determine compliance and shall take corrective action if there is a failure to comply. Access requirements are further defined at 42 CFR 438.206(c)(1)(iv)(v)(vi).

(8) Comply with all State and Federal regulations regarding family planning services and sterilizations, including no restriction on utilization of services.

(9) Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable

(10) Require accurate completion and submission of hospital encounter data claims to support the validity of data used for statistical capitation purposes.

(11) Cooperate with external review agents who have been selected by the State to review the Program.

(12) Report suspected fraud and abuse to the Alabama Medicaid Agency. In addition, these policies and procedures must comply with all mandatory State guidelines and federal guidelines as specified at 42 CFR 438.608(b)(1).

(13) Prohibit discrimination against recipients based on their health status or need for health services as specified at 42 CFR 438.6(d)(3)(4).

(14) Ensure that medical records and any other health and enrollment information that identifies any individual enrollee must be handled in such a manner as to meet confidentiality requirements as specified in 42 CFR 438.224. Each Primary Contractor must establish and implement procedures consistent with confidentiality requirements as specified in 42 CFR 438.224.

(15) The Primary Contractor is not required to provide, reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102(a)(b). If the Primary Contractor elects not to provide the service, then it must provide the related information to the State so that it can be provided to the recipient.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.

History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.04 Primary Contractor Functions/Responsibilities.

(1) Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality care. The care can be provided directly or through subcontracts.

(2) Implement and maintain the Medicaid approved quality assurance system by which access, process and outcomes are measured.

(3) Utilize proper tools and service planning for women assessed to be medically or psychosocially at risk.

(4) Provide recipient choice among Delivering Healthcare Professionals in their network.

(5) Meet all requirements of the Provider Network including maintaining written subcontracts with providers to be used on a routine basis including but not limited to, delivering physicians including obstetricians, family practitioners, general practitioners, etc., anesthesiologists, hospitals, and care coordinators. After contract award and for the 1st 30 days of each succeeding contract year, the Primary Contractor must offer opportunities for participation to all interested potential subcontractors.

The Primary Contractor must notify the Agency, in writing, of changes in the subcontractor base including the subcontractor's name, specialty, address, telephone number, fax number and Medicaid provider number.

(6) Maintain a toll-free line and designated staff to enroll recipients and provide program information.

(7) Require subcontractors to comply with advance directives requirements.

(8) Develop, implement and maintain an extensive recipient education plan covering subjects, such as appropriate use of the medical care system, purpose of care coordination, healthy lifestyles, planning for baby, self-care, etc. All materials shall be available in English and the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in the Agency's efforts to promote the delivery of services in a culturally competent manner including to those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments.

(9) Develop, implement, and maintain a provider education plan, covering subjects such as minimum program guidelines, billing issues, updates from Medicaid, etc. Provide support and assistance to subcontractors to include at minimum program guidelines, billing issues, updates from Medicaid, etc.

(10) Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of the Alabama Medicaid Agency MCP and the services it offers. The Primary Contractor is refrained from marketing activities as specified in Administrative Code 560-X-37-.01(17) and as further defined in 42 CFR 438.104(a) and 438.104(b)(1) et al.

(11) Develop, implement and maintain an educational program explaining how to access the MCP including service locations. Materials shall provide information about recipient rights and

responsibilities, provisions for after-hours and emergency care, referral policies, notification of change of benefits, procedures for appealing adverse decisions, procedures for changing DHCP, exemption procedures and grievance procedures. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight and/or speech impairments.

(12) Develop, implement and maintain a grievance procedure that is easily accessible and that is explained to recipients upon entry into the system.

(13) Develop, implement and maintain a system for handling billing inquiries from recipients and subcontractors so that inquiries are handled in a timely manner.

(14) Develop, implement and maintain a computer based data system that collects, integrates, analyzes and reports. Minimum capabilities include recipient tracking, billing and reimbursement, data analysis and the generation of reports regarding recipient services and utilization.

(15) Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Primary Contractor by any subcontractor which may result in litigation related in any way to the subject matter of this Contract. In the event of the filing of a petition of bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Primary Contractor must ensure that all tasks related to any subcontractor are performed in accordance with the executed office.

(16) Maintain a complete record for each enrolled recipient, at one location, of all services and identify by recipient name, recipient number, date of service, and services provided prior to making payment to that provider of provided. The Primary Contractor must obtain such information from all providers of services service. It is acceptable to maintain one medical record and one administrative record (e.g. care coordination billing, etc.).

(17) Perform claims review prior to submission to Medicaid for Administrative Review.

(18) Advise recipients of services that may be covered by Medicaid that are not covered through the MCP.

(19) Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.

(20) Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Wavier.
History: New ruled filed: August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.05 Payment to Primary Contractors.

(1) Primary Contractors shall be reimbursed at a rate per global delivery as established through the open and competitive bid process.

(2) Claims shall be submitted to Medicaid's Fiscal Agent for payment of the established rate through normal claim submission procedures.

(3) Payment for the delivery of the infant(s) and all pregnancy care is payment in full for all services provided that are covered by the MCP.

(4) Primary Contractors are not allowed to operate Physician Incentive Plans (PIPs) as explained in 42 CFR 422.208, 422.210 and 438.6(h) and 1903(m)(2)(A)(x) of the Social Security Act.

(5) Primary Contractors cannot hold the enrollee liable for covered services in the event of the entity's insolvency, non-payment by the State, or excess payments as specified at 1932 (b)(6) of the Social Security Act and 42 CFR 438.106, 438.6, 438.230 and 438.204.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Wavier.
History: New ruled filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.06 Covered Services.

(1) Primary Contractor Contractors shall have or arrange for a comprehensive system of maternity care that includes all services specified in the ITB used for selection of contractors. Detailed information regarding specific services covered by the MCP is provided in the ITB as well as the MCP Operational Manual

(2) Excluded services shall be covered fee for service by Medicaid. Any fee for service payment is made according to the benefit limits and coverage limitations applicable for the eligibility classification.

Author: Gloria S. Luster, Associate Director, Maternity Care Program.
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.07 Complaints and Grievances.

(1) Each Primary Contractor shall implement an approved written grievance system that meets the requirements of 42 CFR 431.201 including, but not limited to:

(a) Designation of a responsible Grievance Committee.

(b) Two levels of review for the resolution of grievances. The time frame for these reviews shall be based on the nature of the grievance and the immediacy or urgency of the health care needs of the Medicaid recipient.

(c) The primary entry level for complaints shall be a designated responsible representative of each Primary Contractor.

(d) Resolution of grievances of an immediate or urgent nature (life threatening situations, perceived harm, etc.) shall not exceed a forty-eight hour review within the Primary Contractor's review process, which includes subcontractor's review. The Grievance Committee's decision shall be binding unless the Medicaid recipient files a written appeal.

(e) If the Medicaid recipient is not satisfied with the findings of the Grievance Committee, the Medicaid recipient may appeal to the Medicaid Agency for an administrative fair hearing.

(f) All grievances shall be maintained in a log as specified in the MCP Manual.

(2) Handling of Grievance and Appeals. The Primary Contractor must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State established timeframes and as specified in CFR 438.408, 438.410, 438.416, 438.420 and 438.424, including but not limited to:

(a) General Requirements. In handling grievances and appeals, the following requirements must be met:

1. Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing numbers that have adequate TTY/TTD and interpreter capability.
2. Acknowledge receipt of each grievance and appeal.
3. Ensure that the individuals who make decisions on grievances and appeals are individuals-
   (i) Who were not involved in any previous level of review or decision making; and
   (ii) Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.
      (I) An appeal of a denial that is based on lack of medical necessity.
      (II) A grievance regarding denial of expedited resolution of an appeal.
      (III) A grievance or appeal that involves clinical issues.

(b) Special requirements for appeals. The process for appeals must:

1. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
2. Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Primary Contractor must inform the enrollee of the limited time available for this in the case of expedited resolution.)
3. Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
4. Include, as parties to the appeal-
   (i) The enrollee and his or her representative; or
   (ii) The legal representative of a deceased enrollee's estate.

(3) Service Authorizations and Notice of Action

(a) An action is defined as the Primary Contractor

1. denying or limiting authorization of a requested service including the type or level of service;
2. reduction, suspension or termination of a previously authorized service;
3. the denial, in whole or part, of payment for a service;
4. the failure to provide services in a timely manner;
5. the failure to act within specified timeframes

(b) Adverse actions taken by the Primary Contractor must meet the requirements of 42 CFR 438.10, 438.12, 438.404 and 438.210-214.

(c) A service authorization is defined as an enrollee's request for the provision of a service.

(d) Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must meet the requirements of 42 CFR 438.210.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.08 District Designation and Selection of Primary Contractors.

(1) The number of Primary Contractors shall be restricted to one in each of the geographic districts within the State. Geographic districts are based on county designation and are generally comprised of multiple counties. Counties for specific districts shall be identified during the open and competitive bid process for a specified time period as per the ITB.

(2) Primary Contractors shall be selected through evaluation of the ability of the provider's ability to provide required components of the MCP submitted by prospective entities during the competitive bid process as more fully described in the MCP ITB specifications.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended:** Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.09 Quality Improvement.

(1) Each Primary Contractor shall provide an internal quality assurance (QA) system that meets all applicable state and federal guidelines and all quality requirements specified in the procurement document used in the bid process.

(2) Each Primary Contractor's Quality Assurance system shall include an ongoing quality assessment and performance improvement program as specified in 42 CFR 438.20 and a minimum of the following:

(a) Utilization control procedures for the on-going evaluation, on a sample basis, of the quality and accessibility of care provided to program participants

(b) Provide for review by appropriate health professionals of the process followed for providing health services

(c) Provide for systematic data collection of performance and patient results

(d) Provide for interpretation of this data

(e) Provide for making needed changes

(3) Primary Contractors shall have a structured and active Quality Assurance Committee, which shall:

(a) Be composed of, at a minimum, Program Director or designee, a board certified OB/GYN physician, a registered nurse with obstetrical experience, a licensed social worker, and hospital representation

(b) Meet at least quarterly, but more often as needed, to demonstrate that the Committee is following up on all findings and required actions

(c) Operates under the following parameters:

1. Information shall be treated as confidential in accordance with Medicaid rules and regulations and HIPAA - Health Insurance Portability and Accountability Act standards;
2. Committee shall identify actual and potential problems;
3. Committee shall develop appropriate recommendations for corrective action;
4. Committee shall perform follow-up on the recommendations to assure implementation of actions and continued monitoring, if necessary;
5. Committee shall collect data and analyze data;
6. Committee shall include utilization in quality assurance activities;
7. Committee shall include grievances in quality assurance activities;
8. Committee shall document all activities

(4) Each Primary Contractor shall have a written Quality Assurance (QA) Program description including:

1. (a) A scope of work which addresses both the quality and clinical care as well as non-clinical care.

(b) A written Quality Management plan which documents activities including: policies/procedures for performing chart reviews, utilization of provider and enrollee surveys, policies and procedures for analysis of data, procedures for analysis of administrative data and procedures for implementation of corrective action.

(c) A methodology for measurement which includes all demographic groups.

(d) Continuous performance of the activities to be tracked and the timeframes for reporting

(e) Feedback to health professionals regarding performance and patient results.

(f) Identification of individuals/organizations responsible for implementation of the QA plan.

(g) Identification of relevant and measurable standards of care (minimum requirements are contained in the MCP Operational Manual).

(h) Demonstration of measurable improvement of services being received through benchmarks (minimum requirements) are contained in the MCP Operational Manual).

(5) The Primary Contractor shall include in all subcontractor contracts and employment agreements a requirement securing cooperation with the Quality Assurance Program including access to records and responsible parties.

(6) Beneficiary survey results must be made available to the State upon request.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.10 High Risk Protocols.

(1) Each recipient entering the MCP shall be assessed for high risk pregnancy and if indicated referred to a Delivering Health Care Professional qualified to provide high risk care. The recipient may be exempted from the MCP if it is determined that she will require high-risk care throughout antepartum and delivery. Reimbursement shall be fee-for-service if the recipient is exempted from the MCP.

(2) A high-risk assessment tool approved by the Medicaid Agency shall be utilized in performing risk assessments.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.11 Care Coordination.

(1) Each Primary Contractor shall ensure that each woman enrolled in the program receives care coordination. Care coordination is the mechanism for linking and coordinating segments of the service delivery system and assuring that the recipient care needs are met and provided at the appropriate level of care. Care Coordination is a resource that ensures that the care received in the program is augmented with appropriate psychosocial support.

(2) Care coordination requirements are delineated in the bid specification and MCP Operational Manual and include, but are not limited to:

(a) Performing the initial encounter requirements
(b) Psychosocial risk assessment
(c) Assessing medical and social needs
(d) Developing service plans
(e) Providing information and education
(f) Patient tracking
(g) Encounters as specified throughout the course of the pregnancy.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.12 Health Care Professional Panel.

(1) Primary Contractors shall have a delivery system that meets Medicaid standards as defined in the bid. The Primary Contractor shall ensure that there are sufficient health care professionals and hospitals to perform the required duties as specified in the ITB and contract with Medicaid.

(2) Participation opportunities for Delivering Health Care Professionals shall be offered as specified in the ITB.

(3) Primary Contractors shall continually monitor the health care panel to assure adequate access to care for program recipients. Services shall be available to the recipients within the 50-mile/50 minute standard as required by Medicaid.

(4) Primary Contractors shall utilize in-state providers if time/distance or medical necessity is not a factor.

(5) Primary Contractor shall notify Medicaid within one working day of any unexpected changes that would impair the network or create access to care issues.

(6) All subcontracts must meet the requirements of 42 CFR 438.6.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915 (b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. **Amended**: Filed August 22, 2005; effective November 16, 2005.

Rule No. 560-X-45-.13 Recipient Choice.

(1) Women participating in the MCP shall be allowed to select the Delivering Health Care Professional of their choice from within the participating Delivering Health Care Professionals of the Primary Contractor. They may change professionals for cause at any time or without cause within 90 days of enrollment.

(2) Recipients who refuse to select a Delivering Health Care Professional - shall be assigned one by the Primary Contractor who must follow assignment procedures specified in the MCP ITB.

(3) Lists of Delivering Health Care Professionals shall be maintained and utilized in the selection process.

(4) Recipients shall be provided all pertinent information about Delivering Health Care Professional as needed to make an informed selection. A toll free number must be available to recipients for use in selection of Delivering Health Care Professionals as well as for other questions/information.

Author: Gloria S. Luster, Associate Director, Maternity Care Program
Statutory Authority: Section 1932 of the Balanced Budget Act of 1997; Section 1905(t)(3) of the Social Security Act; 42 CFR Section 438; Alabama Medicaid Agency State Plan and approved 1915(b) Waiver.
History: New rule filed: February 19, 1999; effective May 1, 1999. Amended: Filed August 22, 2005; effective November 16, 2005.

Chapter 46. Swing Beds

Rule No. 560-X-46-.01. General Conditions of Participation.

1. Swing beds are defined as hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services. Swing bed hospitals must:
   - (a) Have fewer than 100 beds (excluding newborn and intensive care beds) and be located in a rural area as defined by the Census Bureau based on the most recent census;
   - (b) Be Medicare certified as a swing bed provider;
   - (c) Have a certificate of need for swing beds;
   - (d) Be substantially in compliance with SNF conditions of participation for patient rights, 42 CFR Section 405.1121(K)(2), (3), (4), (7), (8), (10), (11), (13), and (14); specialized rehabilitation services, 42 CFR Section 405.1126(a), (b), and (c); dental services, 42 CFR Section 405.1129; social services 42 CFR Section 405.1130; patient activities, 42 CFR Section 405.1131; and discharge planning, 42 CFR Section 405.1137(h). Most other SNF conditions would be met by virtue of the facilities compliance with comparable conditions of participation for hospitals;
   - (e) Must not have in effect a 24 hour nursing waiver granted under 42 CFR Section 405.1910(c);
   - (f) Must not have had a swing bed approval terminated within the two years previous to application for swing bed participation;
   - (g) Be in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975; and
   - (h) Execute an Alabama Medicaid Agency provider agreement.
2. Refer to Chapter 10 for detailed information on SNF policies and procedures which will be applicable for swing beds.

Authority: Title XIX, Social Security Act; Civil Rights Act of 1964; Rehabilitation Act of 1973; State Plan, Attachment 4.19D; 42 CFR Section Section 405.1121, 405.1126, 405.1130, 405.1131, 405.1137, 482.66; 45 CFR Section Section 80, 84, and 90. Emergency rule effective March 30, 1989. Permanent rule effective July 13, 1989.

Rule No. 560-X-46-.02. Enrollment.

1. Providers wishing to enroll must submit a written request to Medicaid and
   - (a) Proof of current hospital licensure if not already on file at Medicaid,
   - (b) Proof of current Medicare swing bed certification if not already on file at Medicaid,
   - (c) Proof of a CON if not on file at Medicaid.

     Each request will be reviewed for completeness and accuracy prior to approval of the application.
2. Providers approved for enrollment will be issued a provider agreement which must be signed and returned to Medicaid within 30 days of the date mailed to the provider.
3. Provider agreements are valid for no more than 12 calendar months.
4. The effective date of enrollment cannot be earlier than the date of the enrollment application.

Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1A, 4.19D, 42 CFR Section 482.66. Emergency rule effective March 30, 1989. Permanent rule effective July 13, 1989.

Rule No. 560-X-46-.03. Reimbursement.

1. Swing bed services are reimbursed on a per diem basis at the average rate per patient day paid by Medicaid to SNF/ICF combination facilities for routine services furnished during the previous calendar year. There shall be no year end cost settlement. Refer to Chapter 22 for details on rate computation.
2. Ancillary services such as lab, x-ray, and prescription drugs must be billed and reimbursed separately under the appropriate program areas. For example, x-ray services provided in the outpatient department of the hospital should be billed as outpatient hospital services. These services will be subject to routine benefit limitations.
3. The per diem rate includes routine supplies and over the counter medications such as acetaminophen, aspirin, antacids, antidiarrheals, laxatives, and stool softeners which are routinely used in the care of patients.
4. Medicaid may pay the Medicare Part A coinsurance for dually eligible or QMB recipients who qualify under Medicare rules for skilled level of care. An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the average nursing facility rate will be paid.

Authority: Title XIX, Social Security Act; State Plan Attachment 3.1-A, 4.19-D; 42 CFR Sections 447.280, 413.114, 413.53. Emergency rule effective March 30, 1989. Permanent rule effective July 13, 1989. Emergency rule effective January 8, 1990. Effective date of this amendment, February 13, 1991.

Rule No. 560-X-46-.04. Level of Care.

1. In order to receive swing bed services recipients must require SNF level of care on a daily basis. The skilled services provided must be ones that, on a practical basis, can only be provided on an inpatient basis.
2. A condition that does not ordinarily require skilled care may require this care because of a special medical condition. Under such circumstances the service may be considered skilled because it must be performed by or supervised by skilled nursing or rehabilitation personnel.
3. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. A patient may need skilled services to prevent further deterioration or preserve current capabilities.
4. Swing bed admissions not covered by Medicare because they do not meet medical criteria shall also be considered non-covered by Medicaid. Therefore, these services cannot be reimbursed as a straight Medicaid service.

Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, 4.19-B; 42 CFR Section Section 409.30, 409.31, 490.32, 456.600. Emergency rule effective March 30, 1989. Permanent rule effective July 13, 1989.

Rule No. 560-X-46-.05. Services.

1. Swing bed services include care ordinarily provided by a SNF facility (Refer to Chapter 10). Such services include but are not limited to:
    - (a) Nursing care provided by or under the supervision of a registered nurse.
    - (b) Bed and board in a semi-private room. Private accommodations may be utilized if the patient's condition requires that he/she be isolated, the facility has no ward or semi-private rooms, or all semi-private rooms were full at the time of admission and remain so during the recipient's stay.
    - (c) Over the counter drugs including acetaminophen, aspirin, antacids, antidiarrheals, and stool softeners which are routinely used in the care of patients.
    - (d) Personal services and supplies ordinarily furnished by the facility for the comfort and cleanliness of the patient.

(e) Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings) intravenous administration sets, normal intravenous fluids (such as glucose, D5W, D10W).

2. Services must be ordered by a physician.

Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, 4.19-D; 42 CFR Section 409, Subparts C and D. Emergency rule effective March 30, 1989. Permanent rule effective July 13, 1989.

Rule No. 560-X-46-.06. Benefit Limitations.

Swing bed services are unlimited as long as the recipient meets the SNF level of care medically and all other eligibility criteria which includes financial criteria.

Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, 4.19-D; 42 CFR Section 409, Subpart C; Omnibus Budget Reconciliation Act of 1987, Section 4005(b)(2). Emergency rule effective March 30, 1989. Permanent rule effective July 13, 1989.

Rule No. 560-X-46-.07. Billing of Recipients.

1. No eligible Alabama Medicaid recipient is to receive a bill or statement for swing bed services once that recipient has been accepted as a Medicaid patient, except for the appropriate patient liability as described in Chapter 25.
2. It is the responsibility of the provider to follow up with the fiscal agent and/or Medicaid, and not the recipient, on any problem or unpaid claim.
3. A provider agrees to accept as payment in full the amount paid by the State, plus any patient liability amount to be paid by the recipient, for covered services, and further agrees to make no additional charge or charges for covered services to the recipient, sponsor, or family of the recipient.
4. Providers may bill eligible recipients for non-covered services; i.e., private room accommodation charges incurred due to recipient's request, or personal comfort items requested by the recipient.

Authority: Title XIX, Social Security Act; State Plan, 3.1-A, 4.19-D; 42 CFR 447.15, 447.50, 447.55. Emergency rule effective March 30, 1989. Permanent rule effective July 13, 1989.

Rule No. 560-X-46-.08. Admission and Periodic Review.

1. The Medicaid Long Term Care Admissions/Records Unit will perform preadmission review of all Medicaid admissions to assure the necessity and appropriateness of the admission and that a physician has certified the need for swing bed care. Medicaid will certify the level of care required by the patient at the time of admission by utilizing the XIX-LTC-4 form~~s~~.
2. For applications which are not approved by the Long Term Care Admissions/Records Unit, the Medicaid staff physician will review and either approve or deny the medical eligibility.
3. Recipients must meet SNF medical and financial requirements for swing bed admissions just as they are required for SNF admissions. Refer to Chapter 10 and Chapter 25.
4. For recipients who receive retroactive Medicaid eligibility while utilizing swing bed services, the hospital should furnish a form MED-54 attaching all doctors' orders, progress and nurses' notes for the time in question to Long Term Care Admissions/Records Unit.
5. Medical approvals may be issued by the Medicaid Long Term Care Admissions/Records Unit if the information provided to Medicaid documents the need for SNF care and the recipient meets criteria set forth in Rule 560-X-10-.13 for SNF care.

   (a) The admission application packet must be sent to Long Term Care Admissions/Records Unit within 30 days from the date Medicaid coverage is sought and consist of:

      1. A fully completed Medicaid Status Notification Form XIX-LTC-4 including all documentation certified by the applicant’s attending physician to support the need for nursing home level of care. Refer to Rule 560-X-10-.14 for in-depth information.

(b) Once the LTC-4 has been reviewed and approved medically, the facility is notified by the LTC-2 form that the patient is medically and financially eligible. The XIX-LTC-2A is sent to the facility advising that medical eligibility is established, but financial eligibility has not been determined. If the LTC-2A is received, the facility should advise the patient or sponsor of the need to establish financial eligibility by making an application at the District Office.

6. Continued stay reviews are required to assure the necessity and appropriateness of skilled care and effectiveness of discharge planning. Recertification of SNF patients is required 30, 60, and 90 days after admission and then every 60 days thereafter. Physicians must state "I certify" and specify that the patient requires skilled care for continued stay in the facility. Facilities must have written policies and procedures for recertification. The Inspection of Care team will monitor these during medical reviews to assure compliance.

Author: Beverly Rotton, Project Development/Policy Unit, Long Term Care Division

Statutory Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, 4.19-D; 42 CFR Section 435.1009, 456.1, 435.911, 409, Subpart D.

History: Emergency Rule effective March 30, 1989. Permanent rule effective July 13, 1989. Amended: Filed August 20, 1999; effective November 10, 1999.

Rule No. 560-X-46-.09. Inspection of Care/Utilization Review.

1. The Utilization Control Unit at Medicaid will perform inspection of care and utilization review in accordance with 42 CFR Section 456.600 and established Agency policies and procedures.
2. Utilization Committee requirements as outlined in 42 CFR Section 456.300 must also be met.

Authority: Title XIX, Social Security Act; State Plan, Attachment 4.19-D; 42 CFR Section 456.300 and 456.600. Emergency rule effective March 30, 1989. Permanent rule effective July 13, 1989.

Rule No. 560-X-46-.10. Patient Agreements.

Providers of swing bed care must execute a Nursing Facility/Patient Agreement for each Medicaid patient on admission and when any financial terms change. This agreement is executed for patients already eligible for Medicaid and patients who are applying for Medicaid eligibility. The patient or sponsor will be furnished a copy of the completed agreement and a copy is maintained in the facility's files for audit purposes. Refer to 560-X-10-.12 for additional information on patient agreements.

Authority: Title XIX, Social Security Act; State Plan, Attachment 4.19D; 42 CFR Section 405.1121. Emergency rule effective March 30, 1989. Permanent rule effective July 13, 1989.

Chapter 47. Rehabilitative Services

Rule No. 560-X-47-.01. Authority and Purpose.

(1) Rehabilitative services are specialized services of a medical or remedial nature delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness or substance abuse diagnoses. These services will be provided to recipients on the basis of medical necessity.

(2) Direct services may be provided in the client's home, a supervised living situation, organized community settings, such as community centers, health clinics, nursing homes, etc. Direct services can be provided in any setting, except in licensed hospital beds, that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Authority: 42 CFR Section 440.130 (d); Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, Section 4105. State Plan for Medical Assistance, Attachment 3.1-A. Rule effective August 11, 1990; amended August 14, 1991. Emergency rule effective March 1, 1994. Effective date of this amendment June 14, 1994.

Rule No. 560-X-47-.02. Eligibility.

(1) Financial eligibility is limited to individuals eligible for Medicaid under the Alabama State Plan.

(2) Treatment eligibility is limited to individuals with a diagnosis, assigned by a licensed physician or psychologist, of mental illness or substance abuse as listed in the most current International Classification of Diseases - Clinical Modification (ICD-CM). The V codes are not covered for adult rehabilitative treatment services; however, the intake evaluation and diagnostic assessment will be covered even if the resulting diagnosis is a V code. For treatment services provided to children under 21 or adults receiving DHR protective services, the only V code covered for reimbursement is V62.9, unspecified psychosocial circumstance.

(3) Providers of rehabilitative services shall meet the following eligibility requirements:

(a) Shall be in full compliance with applicable federal and state laws and regulations including compliance with the requirements expressed in the current version of the Medicaid Provider Manual, Rehabilitative Services, Chapter 105;

(b) Shall submit evidence to Medicaid of full compliance with 560-47-X-.03; and have such compliance approved in advance; and

(c) Shall execute the Medicaid non-institutional provider agreement with appropriate attachments.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130 (d); Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, Section 4105. State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended August 14, 1991, March 1, 1994, and June 14, 1994.
Amended: Filed March 20, 2001; effective June 15, 2001.
Amended: Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-47-.03. Service Providers.

Service providers must demonstrate that they meet the criteria in either (1), (2), OR (3) and both (4) AND (5) below.

(1) A provider must be certified as a community mental health center by DMH/MR and must have demonstrated the capacity to provide access to the following services through direct provision or referral arrangements:

(a) Inpatient services through referral to community hospitals and/or through the provider physician serving as the attending physician for community hospitalizations;

(b) Substance abuse services including intensive outpatient services and residential services.

(2) For the provision of Substance Abuse Rehabilitative Services an entity:

(a) Must be an organization that is currently certified by the Alabama Department of Mental Health and Mental Retardation (DMH/MR) to provide alcohol and other drug treatment services under the provisions of Chapter 580 of the Alabama Administrative Code; and

(b) Must submit an application to and receive approval by DMH/MR to provide Substance Abuse Rehabilitative Services under the Medicaid Rehabilitative Option program.

(3) For individuals under 21 years of age who need rehabilitative services and who are being served by the Department of Human Resources (DHR), the Department of Public Health (DPH), the Department of Youth Services (DYS), or the Department of Children's Affairs (DCA), these state agencies shall also be eligible rehabilitative services providers if they have demonstrated the capacity to provide either directly or through contract an array of medically necessary services. Additionally, DHR may provide these services to adults in protective service status. At a minimum this array will include:

(a) Individual, group, and family counseling;
(b) Crisis intervention services;
(c) Consultation and education services;
(d) Case management services;
(e) Assessment and evaluation.

(4) A provider must demonstrate the capacity to provide services off-site in a manner that assures the client's right to privacy and confidentiality and must demonstrate reasonable access to services as evidenced by service location(s), hours of operation, and coordination of services with other community resources.

(5) A provider must assure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to an adequate array of services delivered in a flexible manner to best meet their needs. Not all services listed above are covered by Medicaid, but the provider must have demonstrated the capacity to provide these services.

Author: Jerri Jackson , Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130 (d); Social Security Act, Title XIX, Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, Section 4105. State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended August 14, 1991; March 13, 1993; March 1, 1994; June 14, 1994; and December 12, 1996. **Amended:** Filed October 20, 2000; effective January 10, 2001. **Amended:** Filed March 20, 2001; effective June 15, 2001. **Amended**: Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed June 20, 2006; effective September 15, 2006. **Amended:** Filed November 17, 2006; effective February 15, 2007.

Rule No. 560-X-47-.04. Minimum Qualifications for Mental Health, Substance Abuse, and Child & Adolescent Services/Adult Protective Services Professional Staff.

(1) Mental Health Professional Staff qualifications are as follows:

(a) A physician licensed under Alabama law to practice medicine or osteopathy;

(b) A psychologist licensed under Alabama law;

(c) A professional counselor licensed Alabama law;

(d) A marriage and family therapist licensed under Alabama law;

(e) A certified social worker licensed under Alabama law;

(f) A registered nurse who has completed a master's degree in psychiatric nursing;

(g) An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who:

1. has successfully completed a practicum as a part of the requirements for the degree; or

2. has six months post master's level clinical experience supervised by a master's level or above clinician with two years of post graduate clinical experience as described in DMH/MR standards;

(h) Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the Medicaid Provider Manual, Rehabilitative Services.

(i) A pharmacist licensed under Alabama law may provide medication monitoring.

(2) Substance Abuse Professional Staff qualifications are as follows:

(a) Clinical screening and assessments of a substance abuse client shall be performed by a person with at least two years substance abuse treatment experience and meeting any one or more of the following:

1. A person licensed as a physician, psychologist, certified social worker, or counselor; or

2. A person with a master's degree in a clinical area.

(b) Treatment planning and counseling of substance abuse clients shall be performed by any one or more of the following qualified professionals:

1. A person who meets the qualifications stated in (2)(a) above;

2. A person with a master's degree in a clinical area with a clinical practicum;

3. A person with a master's degree in a clinical area that did not require a clinical practicum and one year of supervised clinical experience in a substance abuse treatment/rehabilitation setting;

4. A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience;

5. A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience based, voluntary credentialing process. Such certification must have mutual reciprocity with surrounding states and be nationally recognized. Services will be provided by practitioners as defined above consistent with their training, experience, and scope of practice as established by their respective disciplines and Alabama law.

(c) Services rendered to persons with a primary alcoholism or drug abuse diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the Medicaid Provider Manual, Rehabilitative Services.

(3) Child and Adolescent Services/Adult Protective Services Professional Staff qualifications are as follows:

(a) A physician licensed under Alabama law to practice medicine or osteopathy;

(b) A psychologist licensed under Alabama law;

(c) A professional counselor licensed under Alabama law;

(d) A marriage and family therapist licensed under Alabama law;
(e) A social worker licensed under Alabama law;
(f) A registered nurse who has completed a master's degree in psychiatric nursing;
(g) An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who:
1. has successfully completed a practicum as a part of the requirements for the degree; or
2. has six months post master's level professional experience supervised by a master's level or above with two years of post graduate professional experience.
(h) Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the Medicaid Provider Manual, Rehabilitative Services, Chapter 105.
(i) A pharmacist licensed under Alabama law may provide medication monitoring;

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130 (d); Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, Section 4105. State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended August 14, 1991; March 1, 1994; and June 14, 1994. **Amended:** Filed October 20, 2000; effective January 10, 2001. **Amended:** Filed March 20, 2001; effective June 15, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X- 47-.05. Requirements for Client Intake, Treatment Planning, and Service Documentation.

(1) Requirements for intake, treatment planning, and service documentation are detailed in the Medicaid Provider Manual, Rehabilitative Services, Chapter 105, Section 105.2.3. Manuals may be downloaded from the Medicaid website at www.medicaid.state.al.us.

(2) Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested shall comply with any applicable certification or licensure standards and shall include, at a minimum:
(a) the identification of the specific services rendered;
(b) the date and the amount of time that the services were rendered;
(c) the signature of the staff person who rendered the services;
(d) the identification of the setting in which the services were rendered;
(e) a written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed.

(3) The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials, or computer entry.

(4) When clinical records are audited, the list of required documentation found at 560-X-47-.05(2) will be applied to justify payment by Medicaid. Documentation failing to meet the minimum standards noted above will result in recoupment of payments.
Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130(d), 482.24; Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987; P.L. 100-203, Section 4105; State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended March 1, 1994; and June 14, 1994. **Amended:** Filed June 19, 2000; effective September 11, 2000. **Amended**: Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-47-.06. Covered Services.

(1) Only the following rehabilitative services shall qualify for reimbursement under this program.:

(a) Intake Evaluation,
(b) Physician/Medical Assessment and Treatment,
(c) Diagnostic Testing,
(d) Crisis Intervention and Resolution,
(e) Individual Counseling,
(f) Family Counseling,
(g) Group Counseling,
(h) Medication Administration,
(i) Medication Monitoring
(j) Partial Hospitalization,
(k) Adult Mental Illness Intensive Day Treatment,
(l) Rehabilitative Day Program,
(m) Mental Illness Child and Adolescent Day Treatment,
(n) Treatment Plan Review,
(o) Mental Health Consultation,
(p) Adult Substance Abuse Intensive Outpatient Services,
(q) Child and Adolescent Substance Abuse Intensive Outpatient Services,
(r) In-home Intervention,
(s) Prehospitalization Screening,
(t) Basic Living Skills,
(u) Family Support,
(v) Assertive Community Treatment (ACT),
(w) Program for Assertive Community Treatment (PACT),
(x) Methadone Treatment.

(2) A complete description of each covered service along with benefit limitations is contained in the Medicaid Provider Manual, Rehabilitative Services, Chapter 105. Quarterly manual updates may be downloaded from the Medicaid website: medicaid.state.al.us.

(3) Services shall be provided in a manner that meets the supervisory requirements of the respective certifying or licensing authority or as authorized by state law.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 440.130(d); Social Security Act, Title XIX; Omnibus Budget Reconciliation Act of 1987; P.L. 100-203, Section 4105; State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990. Amended August 14, 1991; March 13, 1993; March 1, 1994; and June 14, 1994. **Amended:** Filed June 19, 2000; effective September 11, 2000. **Amended:** Filed October 20, 2000; effective January 11, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-47-.07. Payment Methodology.

(1) The Medicaid reimbursement for each service provided by a rehabilitative services provider shall be based on the following criteria as found in 42 CFR Sections 447.325 and 447.304 and shall not exceed the lower of:

(a) The customary charges of the provider but not more than the prevailing charges in the locality for comparable services under comparable circumstances; or

(b) the amount billed; or

(c) the fee schedule established by Medicaid as the maximum allowable amount.

(2) Actual reimbursement will be based on the rate in effect on the date of service. Only those services that qualify for reimbursement will be provided under this program.

Author: Karen M. Green, RN, Nurse Analyst, Institutional Services
Statutory Authority: 42 CFR Section 447.304 and 447.325; Social Security Act, Title XIX, State Plan for Medical Assistance, Attachment 4.19-B.
History: Rule effective August 11, 1990; amended August 14, 1991. Emergency rule effective March 1, 1994. Effective date of this amendment June 14, 1994. **Amended:** Filed February 20, 2009; effective May 15, 2009.

Rule No. 560-X-47-.08. Third Party Liability.

(1) The rehabilitative services provider shall make all reasonable efforts to determine if there is a liable third party source, including Medicare, and in the case of liable third party source, utilize that source for payments and benefits prior to applying for Medicaid payments.

(2) Third party payments received after billing Medicaid for service for a Medicaid recipient shall be returned to the Alabama Medicaid Agency.

Authority: 42 CFR Section 433.135; Social Security Act, Title XIX, State Plan for Medical Assistance, Attachment 4.19-B. Rule effective August 11, 1990; amended August 14, 1991.

Rule No. 560-X-47-.09 Payment Acceptance.

(1) Payment made by Medicaid to a rehabilitative services provider shall be considered to be payment in full for covered services rendered.

(2) No Medicaid recipient shall be billed for covered Medicaid services in part or in full for those services rendered, billed, and paid to the provider by the Medicaid fiscal agent. These services are exempt from copays.

(3) No person or entity, except a liable third party source, shall be billed for covered Medicaid services in part or in full.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 447.15; Social Security Act, Title XIX, State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990; amended August 14, 1991. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-47-.10 Confidentiality.

(1) A rehabilitative services provider shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning a recipient, except upon the written consent of the recipient, his attorney, his guardian, or upon subpoena from a court of appropriate jurisdiction.

Authority: 42 CFR Section 431.306; Social Security Act, Title XIX; State Plan for Medical Assistance, Attachment 3.1-A. Rule effective August 11, 1990; amended August 14, 1991.

Rule No. 560-X-47-.11 Records.

(1) The rehabilitative services provider shall make available to the Alabama Medicaid Agency at no charge all information regarding claims submitted and paid for services provided eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. Complete and accurate rehabilitative and fiscal records which fully disclose the extent of the service shall be maintained by the provider. Said records shall be retained for a period of three years plus the current year and/or until completion of any audit.

(2) Documentation of Medicaid clients' signatures may be entered on a sign-in log, service receipt or any other record that can be used to indicate the client's signature and the date of service. Treatment plan review, ACT, PACT, prehospitalization screening, crisis intervention, family support, mental health consultation, and any non-face to face services that can be provided by telephone do not require client signatures.

(3) Documentation failing to meet the minimum standards noted in the Medicaid Provider Manual, Rehabilitative Services, Chapter 105, will result in recoupment of payments.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: 42 CFR Section 431.17, Social Security Act, Title XIX, State Plan for Medical Assistance, Attachment 3.1-A.
History: Rule effective August 11, 1990; August 22, 1990; August 14, 1991; March 1, 1994; and June 14, 1994. **Amended:** Filed October 20, 2000; effective January 11, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005.

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Chapter 48. Federally Qualified Health Centers

Rule No. 560-X-48-.01 General.

1. Federally Qualified Health Centers (FQHCS) are defined as health care centers which meet one of the following requirements:

    (a) receives a grant under Section 329, 330, 340, or 340A of the Public Health Services Act;

    (b) meets the requirements for receiving such a grant as determined by the Secretary based on the recommendations of the Health Resources and Services Administration within the Public Health Service;

    (c) qualifies through waivers of the requirements described above as determined by the secretary for good cause; or

    (d) functions as outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).

2. Services provided by an FQHC include, but are not limited to medically necessary diagnostic and therapeutic services and supplies, provided by a physician, physician assistant, nurse midwife, nurse practitioner, clinical psychologist, clinical social worker, and services and supplies incidental to such services as would otherwise be covered if furnished by a physician as an incident to a physician service. Any other ambulatory service offered by the center which is included in the State Plan is covered except for home health. Home health services are excluded as an FQHC service because home health services are available on a state wide basis.

    (a) Billable services must be designated by procedure codes from the Physicians Current Procedure Terminology (CPT) or by special procedure codes designated by Medicaid for its own use.

3. Reimbursement for other ambulatory services covered by the State Plan includes but is not limited to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21 family planning, prenatal, and dental for individuals under age 21. These services are subject to policies and routine benefit limitations for the respective program areas. Refer to Chapters 11, 14, 43, and 15 of the Administrative Code for details. These services are not counted in the routine benefit limits for medical encounters.

4. FQHC clinic visits and inpatient services are subject to the same routine benefit limitations as physician visits. Refer to Chapter 6 of the Administrative Code for details.

5. The time filing limit for FQHC Providers shall be 365 days after the date of service. Claims received after this time limit will be treated as outdated in accordance with Rule 560-X-1-.17.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services

Statutory Authority: State Plan, Attachment 3.1-A; Section 6404 of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239); Title XIX, Social Security Act.

History: Emergency Rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended September 11, 1993, January 12, 1994, May 13, 1994, May 11, 1995, January 14, 1997, and December 10, 1997. Amended: Emergency Rule filed and effective March 20, 2001. Amended: Filed March 20, 2001; effective June 15, 2001.

Rule No. 560-X-48-.02 Participation.

1. In order to participate in the Title XIX Medicaid Program and to receive Medicaid payment a FQHC must:
   - (a) Submit a completed enrollment packet to EDS Provider Enrollment, including a list of all satellite centers and addresses.
   - (b) Submit appropriate documentation from the Department of Health and Human Services, Public Health Services, that the FQHC meets one of the requirements as stated in Rule No. 560-X-48-.01(1).
   - (c) Submit a budgeted cost report for its initial cost reporting period and thereafter when there is a change in the provider's scope of practice.
   - (d) Federally Funded Health Centers which are Medicare certified must also submit copies of Medicare certification.
   - (e) Certify compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and with the Age Discrimination Act of 1975.
   - (f) Be in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA), for all laboratory testing sites.
2. Provider agreements are valid for the time of the grant budget period which is determined by the Public Health Services and are renewed upon proof that requirements stated in Rule No. 560-X-48-.01 and all other Medicaid requirements continue to be met.
3. The effective date of the enrollment of an FQHC will be the first day of the month in which the enrollment application is received by Medicaid's Fiscal Agent.
4. FQHC are required to notify Medicaid's Fiscal Agent in writing within 5 working days of any of the following changes:
   - (a) The FQHC loses its status as defined in Rule No. 560-X-48-.01 (1);
   - (b) Any changes in dates in the FQHC grant budget period; or
   - (c) Opening(s) and/or closing(s) of any satellite center(s).

Author: Carol Akin, Associate Director, Clinic/Ancillary Services

Statutory Authority: State Plan; Attachments 4.11, 4.13, and 7.2-A, Title XIX, Social Security Act, 42 CFR Section 431.51, 431.52, 431.107. Clinical Laboratory Improvement Amendments of 1988 (CLIA) Public Law 100-578 (42 U.S.C. Section 263a).

History: Emergency rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended April 15, 1993. Amended: Filed January 18, 2002; effective April 18, 2002.

Rule No. 560-X-48-.03 Reimbursement.

1. Federally Qualified Health Centers (FQHCs) will be reimbursed under a prospective payment system as described in Section 1902(aa) of the Social Security Act. Refer to Chapter 56 of the Administrative Code for details.
2. Reimbursement for out-of-state FQHCs will be the lesser of their encounter rate established by their State's Medicaid Department or the average encounter rate established by Alabama Medicaid for in-state facilities.
3. Inpatient and outpatient surgery is reimbursed as fee for service is subject to the routine benefit limitations and policies as stated in Chapter 6 of the Administrative Code.
4. FQHCs that are enrolled as Maternity Waiver primary contractors and/or Pharmacy providers (take home drugs) are reimbursed in accordance with routine benefit limitations and policies as stated in the Administrative Code, Chapters 45 and 16, respectively.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services

Statutory Authority: State Plan, Attachment 4.19-B; Title XIX, Social Security Act; 42 C.F.R., Section 413 et seq.

History: Emergency rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended April 15, 1993, December 10, 1997, and July 10, 1998. Amended: Emergency Rule filed and effective March 20, 2001. Amended: Filed March 20, 2001; effective June 15, 2001. Amended: Filed January 18, 2002; effective April 18, 2002.

Rule No. 560-X-48-.04 Change of Ownership.

1. Medicaid must be notified within thirty (30) days of the date of an FQHC ownership change. The existing contract will be automatically assigned to the new owner, and the new owner shall then be required to execute a new contract with Medicaid as soon as possible after the change of ownership, but in no event, later than thirty (30) days after notification. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.
2. The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency. Refer to Chapter 56 of the Administrative Code for details.

Authority: State Plan, Section 4.3; Title XIX, Social Security Act; 42 C.F.R. Section 431.107. Emergency rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended April 15, 1993. This amendment effective December 10, 1997.

Rule No. 560-X-48-.05 Medicare Deductible and Coinsurance.

Coinsurance will be paid up to the established Medicaid reimbursement rate for each FQHC.

Authority: State Plan, Attachment 3.1-A and 3.2-A; Title XIX, Social Security Act; 42 C.F.R., Section 405.2462(3). Emergency rule effective October 1, 1990. Rule effective January 15, 1991. Rule amended April 15, 1993 and December 10, 1997. Effective date of this amendment July 10, 1998.

Rule No. 560-X-48-.06 Copayment (Cost-Sharing).

1. Medicaid and Medicare/Medicaid related recipients are required to pay and the FQHC's are required to collect the established copayment amount for each medical encounter.
2. The cost-Sharing amount does not apply to services provided for the following:
   - (a) Recipients under 18 years of age
   - (b) Emergencies
   - (c) Pregnancy
   - (d) Family Planning
   - (e) Nursing home residents
3. A provider may not deny services to any eligible individual based on the individual's inability to pay the copayment amount.

Authority: Sate Plan, Attachment 4.18-A; Title XIX, Social Security Act; 42 C.F.R. Section 447.50, 447.53, 447.55, et seq. Emergency rule effective October 1, 1990. Rule effective January 15, 1991.

Rule No. 560-X-48-.07 Billing Recipients.

1. A provider agrees to accept as payment in full the amount paid by Medicaid, plus any copayment amount required to be paid by the recipient for covered items, and further agrees to make no additional charge or charges for covered items to the recipient.
2. Billing recipients for services not paid by Medicaid due to provider correctable errors on submitted claims or the untimely filing of claims is not permissible.

3. A provider may bill the recipient for the copayment amount, for noncovered Medicaid services, and for services provided to a recipient who has exhausted his/her benefit limits.

Authority: 42 C.F.R. Section 447.15; State Plan, Attachment 4.18-A; Title XIX, Social Security Act; Emergency rule effective October 1, 1990. Rule effective January 15, 1991.

Rule No. 560-X-48-.08 Patient's Signature.

1. While a recipient signature is not required on individual claim forms, all providers must obtain a signature to be kept on file, e.g., release forms or sign-in-sheets, as verification that the recipient was present on the date of service for which the provider seeks payment. Exceptions to the recipient signature are listed below.

    (a) Illiterate recipients may make their mark, for example, "X" witnessed by someone with their dated signature after the phrase "witnessed by."

    (b) Interested parties other than the FQHC may sign claim forms for recipients who are not competent to sign because of age, mental, or physical impairment.

    (c) For services rendered in a licensed facility setting, other than the provider's office, the recipient's signature on file in the facility's record is acceptable.

    (d) When payment has been made on claims for which the recipient signature is not available and one of the above exceptions is not applicable, the funds paid to the provider covering this claim will be recovered.

Authority: State Plan, Attachment 4.19-A & D; Alabama State Records Commission; 42 C.F.R. Section 433.32. Rule effective April 15, 1993.

Chapter 49. Certified Nurse Practitioner Program

Rule No. 560-X-49-.01. General.

1. Nurse practitioners who are certified by the appropriate national organization as a family nurse practitioner, pediatric nurse practitioner, or neonatal nurse practitioner are eligible to participate in the Alabama Medicaid Program.
2. A nurse practitioner who is employed by and reimbursed by a facility that receives reimbursement from the Alabama Medicaid Program for services provided by the nurse practitioner (i.e. hospital, rural health clinic, etc.) may not enroll, since their services are already being paid through that facility's cost report.

Authority: State Plan; Attachment 3.1A, Section 6405 of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239); Title XIX, Social Security Act; Emergency rule effective May 22, 1991. Effective date of this Amendment September 11, 1991.

Rule No. 560-X-49-.02. Participation.

1. In order to participate in the Alabama Medicaid Program, a nurse practitioner must complete an enrollment application which is obtained from the Agency's Fiscal Agent.
2. The completed application must be returned to the Fiscal Agent for processing along with the following information:
   (a) Proof of current Alabama registered nurse licensure card.
   (b) Copy of current certification as a certified registered nurse practitioner in the appropriate area of practice, family, pediatric or neonatal from a national certifying agency recognized by Medicaid.
3. Once enrolled, the covered services that are provided by the nurse practitioner must be billed under his/her own provider number.

Authority: Title XIX, Social Security Act; 42 C.F.R., Sections 431.51, 431.107, 440.166, and 441.22; State Plan. Emergency rule effective May 22, 1991. Amended September 11, 1991. Effective date of this Amendment November 10, 1997.

Rule No. 560-X-49-.03 Reimbursement.

1. Nurse practitioners may only bill and be directly reimbursed for those services that are listed in the provider billing manual.
2. In order for services to be covered, nurse practitioners must be under the supervision of a licensed physician.

Authority: State Plan, Attachment 3.1-A, Section 6405 of the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239); Title XIX Social Security Act; 42 C.F.R. Section 431.51; Code of Alabama Section 34-21-1. Emergency rule effective May 22, 1991. Effective date of this Amendment, September 11, 1991.

Rule No. 560-X-49-.04. Limitations on Services.

Limitations on services provided by nurse practitioners are the same as those for a physician and will be counted in the physician visit quota. See Rule No. 560-X-6-.14.

Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, 42 C.F.R. Section 440.230. Emergency rule effective May 22, 1991. Effective date of this Amendment, September 11, 1991.

Rule No. 560-X-49-.05. Billing Recipients.

A nurse practitioner may bill Medicaid recipients for the copay amount, for Medicaid noncovered services and for services provided to a recipient who has exhausted his/her yearly limitations. Conditional collections to be refunded post payment by Medicaid and partial charges for balance of Medicaid allowed reimbursement are not permissible. Billing recipients for services not paid by Medicaid due to provider correctable errors on claims submission or untimely filing is not permissible.

Authority: 42 C.F.R. Section 447.15; State Plan, Attachment 4.18A; Title XIX, Social Security Act; Emergency rule effective May 22, 1991. Effective date of this Amendment, September 11, 1991.

Rule No. 560-X-49-.06 Third Party Requirements.

Nurse practitioners are required to identify recipients who are covered by third party resources and to obtain payment from those resources in accordance with Chapter 20, of the Medicaid Administrative Code.

Authority: Title XIX, Social Security Act; 42 C.F.R. Section 1902(a)(25),401, Social Security Act; Section 22-6-6, Code of Alabama 1975. Emergency rule effective May 22, 1991. Effective date of this Amendment, September 11, 1991.

Rule No. 560-X-49-.07 Copayment (Cost-Sharing)

1. Medicaid recipients are required to pay, and nurse practitioners are required to collect, the designated copayment amount on each visit. The copayment amount does not apply to services provided for the following:
    - (a) Pregnancy
    - (b) Nursing home residents
    - (c) Inpatient hospital visits
    - (d) Recipients under 18 years of age
    - (e) Surgery fees
    - (f) Physical therapy
    - (g) Family planning
2. A provider may not deny services to any eligible individual due to the individuals' inability to pay the cost-sharing amount imposed.

Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, 42 C.F.R. Section 440.230. Emergency rule effective May 22, 1991. Effective date of this Amendment, September 11, 1991.

Chapter 50. Preventive Health Education

Rule No. 560-X-50-.01. General.

1. Preventive Health Education Services are services provided by a physician or other licensed practitioner of the healing arts (within the scope of practice), or by other qualified providers, which are designed to prevent disease, disability, or other health conditions or their progression; to prolong life; and to promote physical and mental health and efficiency.

    (a) Prenatal and Pregnancy Prevention Education.

        1. Prenatal Education consists of a series of classes which teach pregnant women about the process of pregnancy, healthy lifestyles, and prenatal care. These services are covered for Medicaid eligible pregnant women only.

        2. Adolescent Pregnancy Prevention Education consists of a series of classes which teach non-pregnant adolescents about consequences of unintended pregnancy, methods of family planning, and decision making skills. These services are covered for all Medicaid eligible non-pregnant individuals of child bearing age who are eligible for services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, regardless of sex or previous pregnancy.

        3. The purpose of these services is to reduce unintended adolescent pregnancies; decrease the rate of infant mortality; decrease the incidence of maternal complications, low birth weight babies, and other factors associated with the illness, disability or handicap, and deaths among infants and small children.

Authority: State Plan for Medical Assistance; Title XIX Social Security Act; 42 CFR, Section 440.130. Emergency rule effective December 11, 1991. Rule effective March 13, 1992. Rule amended July 11, 1995. Effective date of this amendment May 13, 1996.

Rule No. 560-X-50-.02. Provider Participation.

1. Eligible persons may receive preventive health education services through providers who are under contractual agreement with Medicaid to provide these services.

2. Providers include clinics or other organizations which utilize licensed practitioners of the healing arts within the scope of practice under state law and/or federal regulations as described in section 560-X-50-.02-(4).

3. In cases where there is no licensing board for the instructors listed in 560-X-50-.02-(4), the instructor must either work under the personal supervision of a physician or work in a facility that provides the services under the direction of a physician, such as in a clinic or outpatient hospital. "Under the supervision of" denotes that the physician is familiar with the Medicaid approved preventive information being presented to recipients and is available to the preventive health instructor by telephone, fax, or in person at the time the instructor is providing the preventive health education service. Providers must supply Medicaid with the name and resume of the physician supervising the instructor and maintain documentation sufficient to demonstrate their availability to the instructors.

4. Professional instructors of the provider must meet the following qualifications (according to specialty) as listed below:
    (a) A health educator must have graduated from an accredited four-year college or university with major course work in public health, health education, community health, or health/physical education/recreation with a concentration in health.
    (b) A social worker must be licensed by the Alabama Board of Social Work Examiners.
    (c) A registered nurse must be licensed by the Alabama Board of Nursing as a Registered Nurse.
    (d) A nurse practitioner must have successfully completed a supplemental program in an area of specialization, and must be licensed by the Alabama Board of Nursing as a Registered Nurse and be issued a certificate of approval to practice as a Certified Registered Nurse Practitioner in the area of specialization.
    (e) A nurse midwife must be licensed by the Alabama Board of Nursing as a Registered Nurse and a Certified Nurse Midwife.
    (f) A nutritionist must be licensed as a Registered Dietitian by the American Dietetic Association.
    (g) A nutritionist associate must have graduated from a four-year college or university with major course work in nutrition or dietetics.
    (h) A professional counselor must be licensed by the Alabama Board of Examiners in Counseling.
    (i) A health instructor must have a bachelor's degree with extensive experience in providing instruction in preventive health education supplemented by a training program approved by the Alabama Medicaid Agency.
5. All provider instructors must have successfully completed a training program which is designed to prepare them to provide educational services. This training program must be approved by the Alabama Medicaid Agency.
6. Providers must develop a specific written curriculum for their educational services, including specific course content and objectives for each class. This curriculum must be approved by the Alabama Medicaid Agency.

Authority: State Plan for Medical Assistance; Title XIX, Social Security Act; 42 CFR, Sections 440.130 and 401 et seq. Emergency rule effective December 11, 1991. Rule effective March 13, 1992. Rule amended July 11, 1995. Effective date of this amendment May 13, 1996.

Rule No. 560-X-50-.03. Recipient Eligibility.

1. Eligibility of recipients for preventive health education services varies according to the type of service being provided.
    (a) Prenatal Education services are limited to those Medicaid eligible females who are pregnant (as evidenced by physical examination or a positive pregnancy test).
    (b) Adolescent Pregnancy Prevention Education is available to all Medicaid eligible non-pregnant individuals of childbearing age who are eligible for services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, regardless of sex or previous pregnancy.

Authority: State Plan for Medical Assistance; Title XIX, Social Security Act; 42 CFR, Section 440.130. Emergency rule effective December 11, 1991. Rule effective March 13, 1992. Rule amended July 11, 1995. Effective date of this amendment May 13, 1996.

Rule No. 560-X-50-.04. Covered Services.

1. Preventive Health Education Services do not include services for which payment shall be made under other provisions.
2. Preventive Health Education Services are covered when provided by a Medicaid enrolled preventive health education service provider.
   (a) Prenatal Education visits are limited to 12 visits per recipient during each two-year period beginning with the first date of service.
   (b) Adolescent Pregnancy Prevention Education visits are unlimited.

Authority: State Plan for Medical Assistance; Title XIX, Social Security Act; 42 CFR, Sections 440.130, 441.20, and 441.57. Emergency rule effective December 11, 1991. Rule effective March 13, 1992. Rule amended July 11, 1995. Effective date of this amendment May 13, 1996.

Rule No. 560-X-50-.05. Copayment (Cost Sharing).

Medicaid recipients shall not be required to pay and providers may not collect a copayment for any of these services. Refer to Rule No. 560-X-1-.25 for copay information.

Authority: State Plan for Medical Assistance, Attachment 4.19B, page 12; Title XIX, Social Security Act; 42 C.F.R. Section 440.130. Emergency rule effective December 11, 1991. Rule effective March 13, 1992. Effective date of this amendment July 11, 1995.

Rule No. 560-X-50-.06. Payment Acceptance.

1. The provider shall not charge Medicaid for services rendered on a no-cost basis to the general public except where such services are provided pursuant to Section 1903 (c) of the Social Security Act or such services are provided by a Title V Grantee pursuant to Section 1902 (a) (11) (B) of the Social Security Act.
2. Eligible Medicaid recipients are not to be billed for covered services once the recipient has been accepted as a Medicaid patient.
3. It is the responsibility of the provider to follow-up with the fiscal agent or Medicaid on denied claims.
4. The recipient is not responsible for any difference between billed charges and Medicaid allowed charges.
5. The recipient may be billed for non-covered services.
6. Preventive Health Education Services shall be billed on the HCFA 1500 claim form, utilizing locally assigned procedure codes. The appropriate ICD-9-CM diagnosis code shall be indicated on the claim form.
7. Reimbursement to governmental agency providers will be based on a negotiated rate not to exceed actual costs as would occur through the efficient and economic operation by the provider. Reimbursement to non-governmental providers will be based on Medicaid's established fee schedule, not to exceed the prevailing rate in the locality for comparable services offered under comparable conditions.
8. (8) Claims submitted for which there is no documentation, or for charges in excess or in violation of the provider's contractual agreement, are subject to recoupment by the Agency, and to referral for investigation and possible prosecution for fraud.

Authority: State Plan for Medical Assistance; Title XIX, Social Security Act; 42 C.F.R Section 447.15. Emergency rule effective December 11, 1991. Rule effective March 13, 1992. Effective date of this amendment July 11, 1995.

Rule No. 560-X-50-.07. Confidentiality.

1. The provider shall not disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon written consent of the recipient, his attorney, or his/her guardian, or upon subpoena from a court of appropriate jurisdiction. See Rule 560-X-30-.05, Third Party, for additional requirements regarding release of information.
2. The provider must safeguard clinical records against loss, destruction, and/or unauthorized use.

Authority: State Plan for Medical Assistance; Title XIX, Social Security Act; 42 C.F.R. Section 431.306. Emergency rule effective December 11, 1991. Rule effective March 13, 1992. Effective date of this amendment July 11, 1995.

Rule No. 560-X-50-.08. Maintenance of Records.

1. The provider shall make available to the Alabama Medicaid Agency at no charge all information regarding claims for services provided to eligible recipients. The provider shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. Complete and accurate fiscal records which fully disclose the extent and cost of services shall be maintained by the provider.
2. The provider shall maintain documentation of Medicaid clients' signatures. These signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the clients' signatures and dates of service.
3. All records shall be maintained for a period of at least three (3) years plus the current fiscal year. If audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three (3) year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three (3) year period, the records shall be retained until resolution and finality thereof. Such records shall be kept in a form that will facilitate the establishment of a complete audit trail in the event such items are audited.

Authority: State Plan for Medical Assistance; Title XIX Social Security Act; 42 C.F.R. Sections 431.17 and 433.32. Emergency rule effective December 11, 1991. Rule effective March 13, 1992.

Chapter 51. Hospice Care.

Rule No. 560-X-51-.01. Hospice Care - General.

(1) Hospice care services are available if medically necessary for all Medicaid eligible recipients certified as being terminally ill. Medical certification is required by the individual's attending physician; however, if the recipient does not have a primary attending physician, certification may be given by the Hospice Team physician or the hospice medical director. Certification of the terminal illness of an individual who elects hospice shall be based on the attending physician, hospice team physician, or hospice medical director's clinical judgment regarding the normal course of the individual's illness. Certifications of terminal illness must include specific findings and other medical documentation including, but not limited to, medical records, lab x-rays, pathology reports, etc. Hospice care means services which are necessary for the palliation or management of the terminal illness and related conditions.

(2) Alabama Medicaid Hospice Care services are subject to Medicare special election periods applicable to hospice care. Medicaid will utilize the most recent benefit periods established by the Medicare Program.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.20; State Medicaid Manual; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991. Emergency Rule effective May 15, 1991. Amended August 14, 1991 and September 9, 1998. Amended: Filed March 20, 2001; effective June 20, 2001.

Rule No. 560-X-51-.02. Definitions.

(1) Hospice means a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals, meets the Medicare conditions of participation for hospices and has a valid Medicaid provider agreement.

(2) Attending physician means a doctor of medicine or osteopathy who is identified by the individual at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care.

(3) Election statement means a written statement electing hospice care filed by a recipient, or his representative, with a hospice.

(4) An election period is a predetermined timeframe for which an individual may elect to receive Medicaid coverage of hospice care during the individual's lifetime. Election periods consist of:

(a) An initial 90-day period.
(b) A subsequent 90-day period.
(c) A subsequent 60-day period.
(d) Unlimited subsequent extensions of 60 day periods during the individual's lifetime.

(5) Employee means an employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. "Employee" also refers to a volunteer under the jurisdiction of the hospice.

(6) Interdisciplinary team means a group of persons employed by the hospice which includes at least:

(a) One physician
(b) One registered nurse

(c) One social worker
(d) One pastoral or other counselor.

(7) Plan of care means a written plan of care established by the attending physician, the medical director, or physician designee and interdisciplinary team prior to providing care.

(8) Terminally ill means that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

(9) Representative means a person who, because of the terminally ill individual's mental or physical incapacity, is authorized in accordance with state law to elect or revoke an election for hospice care or terminate medical care on behalf of that individual.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.3, 418.21, 418.58, and Section 418.68; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991. Emergency Rule effective May 15, 1991. Amended August 14, 1991. **Amended:** Filed February 17, 2006; effective May 16, 2006. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-51-.03. Provider Eligibility and Certification of Terminal Illness Requirements.

(1) A provider of hospice services shall meet the definition of hospice in Rule No. 560-X-51-.02(1).

(2) The provider shall participate in Title XVIII (Medicare) and shall be certified under Medicare standards.

(3) Within two days after hospice care is initiated, the provider shall obtain terminally ill certification statements on all recipients and shall maintain them for the duration of hospice care. If the hospice does not obtain a written certification as described, verbal certification may be obtained, but written certification must be obtained no later than eight days after care is initiated. For each subsequent period, the hospice must obtain written certification within two calendar days of the beginning of the period. **The hospice must not recertify an individual who reaches a point of stability and is no longer considered terminally ill. The individual must return to traditional Medicaid benefits.**

(4) All services shall be provided under a written plan of care established and maintained for each individual admitted to a hospice program, and the care provided shall be in accordance with the plan.

(5) In addition to the completion of a provider enrollment agreement, a hospice must also submit the following information to the Alabama Medicaid Agency or its designee:
(a) A letter from the State licensing unit showing the permit number and effective date of permit.
(b) A document from the licensing unit showing that the hospice meets requirements for the Medicare program.
(c) A signed document indicating that the hospice is in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
(d) A copy of the written notification to the hospice from the Medicare fiscal intermediary showing the approved reimbursement rate, the fiscal year end, and the Medicare provider number.

(6) The hospice provider must verify the recipient's Medicaid eligibility.

(7) The hospice must complete and submit to Medicaid required hospice election and physician certification documentation for Medicaid coverage of hospice care. (See Chapter 18 of the Medicaid Provider Manual Section 18.3. Medicaid Approval of Hospice Care). This information shall be kept on file and shall be made available to the Alabama Medicaid Agency for auditing purposes.

(8) The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal, medical necessity, and eligibility requirements are not met.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.20 and Section 418.22; OBRA '90; State Medicaid Manual; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991. Emergency Rule effective May 15, 1991. Amended August 14, 1991, January 13, 1993, and October 1, 1993. **Amended:** Filed March 20, 2001; effective June 20, 2001. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed May 20, 2003; effective August 21, 2003. **Amended:** Filed February 17, 2006; effective May 16, 2006. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-51-.04. Recipient Eligibility.

In order to be eligible to elect hospice care under Medicaid, an individual must be:

(1) Medicaid eligible.

(2) Certified by a physician as terminally ill and require hospice services which are medically necessary for the palliation or are medically necessary for symptom and pain management of related to the terminal illness. Certification of terminal illness must include specific clinical findings and other medical documentation including, but not limited to, medical records, lab x-rays, pathology reports, etc. **A person who reaches a point of stability and is no longer considered terminally ill must not be recertified for hospice services. The individual must be discharged to traditional Medicaid benefits.** Medicaid eligibility for the Hospice program, for recipients who are not dually eligible for Medicare, is based upon financial and medical criteria. The following medical criteria must be present for the terminal illnesses listed below. For diagnoses not found in the Alabama Medicaid Agency administrative code or for pediatric cases medical necessity review will be conducted on a case-by-case basis.

(a) ***Hospice Criteria for Adult Failure to Thrive Syndrome***

1. Terminal Illness Description: The adult failure to thrive syndrome is characterized by unexplained weight loss, malnutrition and disability. The syndrome has been associated with multiple primary conditions (e.g., infections and malignancies), but always includes two defining clinical elements, namely nutritional impairment and disability. The nutritional impairment and disability associated with the adult failure to thrive syndrome must be severe enough to impact the patient's short-term survival. The adult failure to thrive syndrome presents as an irreversible progression in the patient's nutritional impairment/disability despite therapy (i.e., treatment intended to affect the primary condition responsible for the patient's clinical presentation).

2. Criteria for initial certification or recertification: Criteria below must be present at the time of **initial certification or re-certification** for hospice. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less if the terminal illness runs its normal course. Patients must meet **(i) and (ii)** below:

(i) The nutritional impairment associated with the adult failure to thrive syndrome must be severe enough to impact a beneficiary's weight. The Body Mass Index (BMI) of beneficiaries electing the Medicaid Hospice Benefit for the adult failure to thrive syndrome must be below 20 kg/m^2 and the patient must be either declining enteral/parenteral nutritional support or has not responded to such nutritional support, despite an adequate caloric intake (calorie counts must be documented in medical records) and **must show greater than or equal to 10 % weight loss in the 90 day period immediately preceding Medicaid election of the hospice benefit**.

(ii) The disability associated with the adult failure to thrive syndrome should be such that the individual is significantly disabled. Significant disability must be demonstrated by a Karnofsky or Palliative Performance Scale value less than or equal to 40%.

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(b) Hospice Criteria for Adult HIV Disease

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria:

HIV Disease (**i) and (ii)** must be present; factors from (iii) will add supporting documentation)

(i) CD4+ Count less than 25 cells/mcL or persistent viral load greater than 100,000 copies/ml, plus ***one*** of the following:

(I) CNS lymphoma

(II) Untreated, or not responsive to treatment, wasting (loss of 33% lean body mass)

(III) Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused

(IV) Progressive multifocal leukoencephalopathy

(V) Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy

(VI) Visceral Kaposi's sarcoma unresponsive to therapy

(VII) Renal failure in the absence of dialysis

(VIII) Cryptosporidium infection

(IX) Toxoplasmosis, unresponsive to therapy

(ii) Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of less than or equal to 50

(iii) Documentation of the following factors will support eligibility for hospice care:

(I) Chronic persistent diarrhea for one year

(II) Persistent serum albumin less than 2.5 gm/dl

(III) Age greater than 50 years

(IV) Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease

(V) Advanced AIDS dementia complex

(VI) Toxoplasmosis

(VII) Congestive heart failure, symptomatic at rest, New York Heart Association (NYHA) classification Stage IV

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Both (i) and (ii) must be met. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet one of the conditions in (i) and meet the requirement in (ii):

(i) Persistent viral load greater than-100,000 copies/ml, plus ***one*** of the following:

(I) CNS lymphoma

(II) Untreated, or not responsive to treatment, wasting (loss of 33% lean body mass)

(III) Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused

(IV) Progressive multifocal leukoencephalopathy

(V) Systemic lymphoma, unresponsive or partially responsive to chemotherapy

(VI) Visceral Kaposi's sarcoma unresponsive to therapy

(VII) Renal failure in the absence of dialysis
(VIII) Cryptosporidium infection
(IX) Toxoplasmosis, unresponsive to therapy

(ii) Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of less than or equal to 50

(iii) Documentation of the following factors will support eligibility for hospice care:

(I) Chronic persistent diarrhea for one year
(II) Persistent serum albumin less than 2.5 gm/dl
(III) Age greater than 50 years
(IV) Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease
(V) Advanced AIDS dementia complex
(VI) Toxoplasmosis
(VII) Congestive heart failure, symptomatic at rest, New York Heart Association (NYHA) classification Stage IV

4. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy
(ii) Absence of supporting documentation of progression or rapid decline
(iii) Failure to document terminal status of six months or less.
(iv) Patient on protease inhibitors.

(c) Hospice Criteria for Adult Pulmonary Disease

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease: (**i) and (ii)** must be present; documentation of (iii), (iv) and/or (v) will lend supporting documentation:

(i) Severe chronic lung disease as documented by both factors below:

(I) Patient with Forced Expiratory Volume in one second [FEV1], after bronchodilator, less than 30% of predicted and disabling dyspnea at rest, poorly responsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough (documentation of Forced Expiratory Volume in one second [FEV1], after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea and must be provided).

(II) Progression of end stage pulmonary disease as documented by two or more episodes of pneumonia or respiratory failure requiring ventilatory support within the last six months. Alternatively, medical record documentation of serial decrease in FEV1 greater than 40 ml/year for the past two years can be used to demonstrate progression.

(ii) Hypoxemia at rest on room air, with a current ABG PO2 at or below 59 mm Hg or oxygen saturation at or below 89% taken at rest or hypercapnia, as evidenced by PCO2 greater than or equal to 50 mmHg (these values may be obtained from recent hospital records).

(iii) Cor pulmonale and right heart failure (RHF) secondary to pulmonary disease (e.g., not secondary to left heart disease or valvulopathy).

(iv) Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

(v) Resting tachycardia greater than 100/min.

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet (i) and (ii) below:

(i) Severe disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough.

(ii) Hypoxemia at rest on room air, with a current ABG PO2 at or below 59 mm Hg or oxygen saturation at or below 89% taken at rest or hypercapnia as evidenced by PCO2 greater than or equal to 50 mmHg.

4. Reasons for Denial
   (i) Patients not meeting the specific medical criteria in this policy.
   (ii) Absence of supporting documentation of progression or rapid decline.
   (iii) Failure to document terminal status of six months or less.

(d) Hospice Criteria for Adult Alzheimer's Disease & Related Disorders

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less. Alzheimer's disease and related disorders are further substantiated with medical documentation of a progressive decline in the Reisburg Functional Assessment Staging (FAST) Scale, within a six month period of time, prior to the Medicaid hospice election.

2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. Alzheimer's disease and related disorders may support a prognosis of six months or less under many clinical scenarios. The structural and functional impairments associated with a primary diagnosis of Alzheimer's disease are often complicated by co morbid and/or secondary conditions. Co-morbid conditions affecting beneficiaries with Alzheimer's disease are by definition distinct from the Alzheimer's disease itself- examples include coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD). Secondary conditions on the other hand are directly related to a primary condition – in the case of Alzheimer's disease examples include delirium and pressure ulcers. The Reisberg Functional Assessment Staging (FAST) Scale has been used for many years to describe Medicare beneficiaries with Alzheimer's disease and a prognosis of six months or less. The FAST Scale is a 16-item scale designed to parallel the progressive activity limitations associated with Alzheimer's disease. Stage 7 identifies the threshold of activity limitation that would support a six-month prognosis; however at least 4 of the 6 substage FAST scale indicators must be present. The FAST Scale does not address the impact of co- morbid or secondary conditions. The presence of secondary conditions is thus considered separately by this policy and **(i)** must be present; factors from (ii) will add supporting documentation. The FAST Scale is designed to parallel the progressive activity.

   (i) To be eligible for hospice, beneficiaries with Alzheimer's disease must have a FAST level equal to 7.

FAST Scale Items:

Stage #1: No difficulty, either subjectively or objectively
Stage #2: Complains of forgetting location of objects; subjective work difficulties
Stage #3: Decreased job functioning evident to coworkers; difficulty in traveling to new locations
Stage #4: Decreased ability to perform complex tasks (e.g., planning dinner for guests; handling finances)
Stage #5: Requires assistance in choosing proper clothing
Stage #6: Decreased ability to dress, bathe, and toilet independently:

- Sub-stage 6a: Difficulty putting clothing on properly
- Sub-stage 6b: Unable to bathe properly; may develop fear of bathing
- Sub-stage 6c: Inability to handle mechanics of toileting (i.e., forgets to flush, does not wipe properly)
- Sub-stage 6d: Urinary incontinence
- Sub-stage 6e: Fecal incontinence

Stage #7: Loss of speech, locomotion, and consciousness:

- Sub-stage 7a: Ability to speak limited (1 to 5 words a day)
- Sub-stage 7b: All intelligible vocabulary lost
- Sub-stage 7c: Non-ambulatory
- Sub-stage 7d: Unable to sit up independently
- Sub-stage 7e: Unable to smile
- Sub-stage 7f: Unable to hold head up

   (ii) Documentation of specific secondary conditions (i.e. Pressure Ulcers, recurrent UTI, Dysphagia, Aspiration Pneumonia) related to Alzheimer's Disease will support eligibility for hospice care.

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criterion:

(i) To be eligible for hospice, beneficiaries with Alzheimer's disease must have a FAST level equal to 7; however at least 4 of the 6 substage FAST scale indicators must be present.

FAST Scale Items:

Stage #1: No difficulty, either subjectively or objectively

Stage #2: Complains of forgetting location of objects; subjective work difficulties

Stage #3: Decreased job functioning evident to coworkers; difficulty in traveling to new locations

Stage #4: Decreased ability to perform complex tasks (e.g., planning dinner for guests; handling finances)

Stage #5: Requires assistance in choosing proper clothing

Stage #6: Decreased ability to dress, bathe, and toilet independently:

- Sub-stage 6a: Difficulty putting clothing on properly
- Sub-stage 6b: Unable to bathe properly; may develop fear of bathing
- Sub-stage 6c: Inability to handle mechanics of toileting (i.e., forgets to flush, does not wipe properly)
- Sub-stage 6d: Urinary incontinence
- Sub-stage 6e: Fecal incontinence

Stage #7: Loss of speech, locomotion, and consciousness:

- Sub-stage 7a: Ability to speak limited (1 to 5 words a day)
- Sub-stage 7b: All intelligible vocabulary lost
- Sub-stage 7c: Non-ambulatory
- Sub-stage 7d: Unable to sit up independently
- Sub-stage 7e: Unable to smile
- Sub-stage 7f: Unable to hold head up

(ii) Documentation of specific secondary conditions (i.e. Pressure Ulcers, recurrent UTI, Dysphagia, Aspiration Pneumonia) related to Alzheimer's Disease will support eligibility for hospice care.

4. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(e) Hospice Criteria for Adult Stroke and/or Coma

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of stroke. Patients must meet **(i) and (ii) below:**

(i) A Palliative Performance Scale (PPS) of less than or equal to 40.

(I) Degree of ambulation-Mainly in bed

(II) Activity/extent of disease able to do work; extensive disease

(III) Ability to do self-care -Mainly Assistance

(IV) Food/fluid intake-Normal to reduced

(V) State of consciousness -Either fully conscious or drowsy/confused

(ii) Inability to maintain hydration and caloric intake with any one of the following:

(I) Weight loss greater than 10% during previous 3 months

(II) Weight loss greater than 7.5% in previous 6 weeks

(III) Serum albumin less than 2.5 gm/dl
(IV) Current history of pulmonary aspiration without effective response to speech language pathology interventions to improve dysphagia and decrease aspiration events.
(V) Calorie counts documenting inadequate caloric/fluid intake.
(iii) The medical criteria for 3 listed below would support a terminal prognosis for individuals with a diagnosis of coma (any etiology):
(I) Comatose patients with any 3 of the following on day three or after of coma:
I. abnormal brain stem response
II. absent verbal response
III. absent withdrawal response to pain
IV. increase in serum creatinine greater than 1.5 mg/dl

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the criteria in (i) and (ii):
(i)A Palliative Performance Scale (PPS) of less than or equal to 40.
(ii) Inability to maintain hydration and caloric intake with any one of the following:
(I) Weight loss greater than or equal to 10% during previous 3 months
(II) Weight loss greater than or equal to 7.5% in previous 6 weeks
(III) Serum albumin less than 2.5 gm/dl
(IV) Current history of pulmonary aspiration without effective response to speech language pathology interventions to improve dysphagia and decrease aspiration events.
(V) Calorie counts documenting inadequate caloric/fluid intake. (Patient's height and weight-caloric intake is too low to maintain normal BMI or fewer calories than necessary to maintain normal BMI -determine with caloric counts)
(iii) The medical criteria for 3 listed below would support a terminal prognosis for individuals with a diagnosis of coma (any etiology):
(I) Comatose patients with any 3 of the following on day three or after of coma:
I. abnormal brain stem response
II. absent verbal response
III. absent withdrawal response to pain
IV. progressive increase in serum creatinine greater than 1.5 mg/dl

4. Reasons for Denial
(i) Patients not meeting the specific medical criteria in this policy.
(ii) Absence of supporting documentation of progression or rapid decline.
(iii) Failure to document terminal status of six months or less.

(f) Hospice Criteria for Adult Amyotrophic Lateral Sclerosis (ALS)

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.
2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. ALS tends to progress in a linear fashion over time. The *overall* rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases. No *single* variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist. In end-stage ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to hospice care, the decision to institute either artificial ventilation or artificial feeding will significantly alter six-month prognosis. Examination by a

neurologist within three months of assessment for hospice is required, both to confirm the diagnosis and to assist with prognosis. Patients will be considered to be in the terminal stage of ALS (life expectancy of six months or less) if they meet the following criteria (must fulfill **i, ii, *or* iii**):

(i) The patient must demonstrate critically impaired breathing capacity

(I) Critically impaired breathing capacity as demonstrated by ***all*** the following characteristics occurring within the 12 months preceding initial hospice certification:

- Vital capacity (VC) less than 30% of normal
- Continuous dyspnea at rest
- Hypoxemia at rest on room air, with a current ABG PO2 at or below 59mm HG or oxygen saturation at or below 89%
- Patient declines artificial ventilation

(ii) Patient must demonstrate ***both*** rapid progression of ALS and critical nutritional impairment

(I) Rapid progression of ALS as demonstrated by ***all*** the following characteristics occurring within the 12 months preceding initial hospice certification:

- Progression from independent ambulation to wheelchair or bed bound status
- Progression from normal to barely intelligible or unintelligible speech
- Progression from normal to pureed diet
- Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in ***all*** ADLs.

(II) Critical nutritional impairment as demonstrated by ***all*** the following characteristics occurring within the 12 months preceding initial hospice certification:

- Oral intake of nutrients and fluids insufficient to sustain life
- Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

(iii) Patient must demonstrate ***both*** rapid progression of ALS and life-threatening complications

(I) Rapid progression of ALS, see (ii) (I) above

(II) Life-threatening complications as demonstrated by one of the following characteristics occurring within the 12 months preceding initial hospice certification:

- Two or more episodes of recurrent aspiration pneumonia (with or without tube feedings)
- Upper urinary tract infection (pyelonephritis)
- Sepsis
- Other medical complications not identified above will be reviewed on a case by case basis with appropriate medical justification

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet (i) and (ii) below:

(i) The patient must demonstrate critically impaired breathing capacity

(I) Critically impaired breathing capacity as demonstrated by ***all*** the following characteristics:

- Continuous dyspnea at rest
- Hypoxemia at rest on room air with a current ABG PO2 at or below 59 mmHg or oxygen saturation at or below 89%
- Patient declines artificial ventilation

(ii) Patient must demonstrate rapid progression of ALS and at least one life-threatening complication.

(I) Life-threatening complications as demonstrated by one of the following characteristics:

- Two or more episodes of recurrent aspiration pneumonia (with or without tube feedings)
- Upper urinary tract infection (pyelonephritis)
- Sepsis
- Other medical complications not identified above will be reviewed on a case by case basis with appropriate medical justification

4. Reasons for Denial
   (i) Patients not meeting the specific medical criteria in this policy.
   (ii) Absence of supporting documentation of progression or rapid decline.
   (iii) Failure to document terminal status of six months or less.

(g) Hospice Criteria for Adult Cancer

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.
2. Criteria for initial certification or recertification: Criteria below must be present at the time of **initial certification or re-certification** for hospice. Patients will be considered to be in the terminal stage of cancer (life expectancy of six months or less) if (**i**) **and (ii)** below:
   (i) Documentation of metastasis or final disease stage is required with evidence of progression.

   (ii) Palliative Performance Scale (PPS) less than or equal to 50.
3. Reasons for Denial
   (i) Patients not meeting the specific medical criteria in this policy.
   (ii) Absence of supporting documentation of progression or rapid decline.
   (iii) Failure to document terminal status of six months or less.

(h) Hospice Criteria for Adult Heart Disease

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.
2. Criteria for initial certification or recertification: Criteria below must be present at the time of **initial certification or re-certification** for hospice. The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of heart disease. Medical criteria **(i) and (ii)** must be present as they are important indications of the severity of heart disease and would thus support a terminal prognosis if met.
   (i) When the recipient is approved or recertified the:
      (I) Patient is already optimally treated with diuretics **and** vasodilators, which may include angiotensin-converting enzymes (ACE) inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension
      or hyperkalemia, **or** evidence of treatment failure prohibit the use of ACE inhibitors **or** the combination of hydralazine and nitrates, **or** patient voluntarily declines treatment the documentation must be present in the medical records **or** with lab results and medical records submitted upon request.
   (ii) The patient has significant symptoms of recurrent congestive heart failure (CHF) at rest, and is classified as a New York Heart Association (NYHA) Class IV:
      (I) Unable to carry on any physical activity without symptoms
      (II) Symptoms are present even at rest
      (III) If any physical activity is undertaken, symptoms are increased
   (iii) Documentation of the following factors may provide additional support for end stage heart disease:
      (I) Treatment resistant symptomatic supraventricular or ventricular arrhythmias
      (II) History of cardiac arrest or resuscitation

(III) History of unexplained syncope
(IV) Brain embolism of cardiac origin
(V) Concomitant HIV disease
(VI) Documentation of ejection fraction of 20% or less
(VII) Angina pectoris, at rest

3. Reasons for Denial
(i) Patients not meeting the specific medical criteria in this policy.
(ii) Absence of supporting documentation of progression or rapid decline.
(iii) Failure to document terminal status of six months or less.

(i) Hospice Criteria for Adult Liver Disease

1. Terminal Illness Description: Coverage of hospice care depends upon a physician's certification of an individual's prognosis of a life expectancy of six months or less if the terminal illness runs its normal course.

2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. Patients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria. Documentation in the record must support both **(i) and (ii)**.

(i) The patient ***must meet both*** (I) and (II):
(I) Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) greater than 1.5
(II) Serum albumin less than 2.5 gm/dl

(ii) End stage liver disease is present and the patient shows at least **one** of the following:
(I) ascites, refractory to treatment or patient non-complaint
(II) spontaneous bacterial peritonitis
(III) hepatorenal syndrome (elevated serum creatinine and BUN with oliguria (less than 400ml/day) and urine sodium concentration less than10 mEq/l
(IV) hepatic encephalopathy, refractory to treatment, or patient non-compliant
(V) recurrent variceal bleeding, despite intensive therapy

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria:

(i) End stage liver disease is present and the patient shows at least **one** of the following:
(I) ascites, refractory to treatment or patient non-complaint
(II) spontaneous bacterial peritonitis
(III) hepatorenal syndrome (elevated serum creatinine and BUN with oliguria (less than 400ml/day) and urine sodium concentration less than10 mEq/l
(IV) hepatic encephalopathy, refractory to treatment, or patient non-compliant
(V) recurrent variceal bleeding, despite intensive therapy

4. Reasons for Denial
(i) Patients not meeting the specific medical criteria in this policy.
(ii) Absence of supporting documentation of progression or rapid decline.
(iii) Failure to document terminal status of six months or less.

(j) Hospice Criteria for Adult Renal Disease

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. Patients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria:

(i) ***Acute renal failure*** **(I), (II), and (III)** must be present~~)~~

(I) Creatinine clearance less than 10 cc/min (less than 15 cc/min. for diabetes)

(II) Serum creatinine greater than 8.0 mg/dl (greater than 6.0 mg/dl for diabetes)

(III) Fractional Excretion of Sodium (FENa) greater than 2

(ii) ***Chronic renal failure*** **(I), (II), and (III)** must be present~~)~~

(I) Creatinine clearance less than 10 cc/min (less than 15cc/min for diabetes)

(II) Serum creatinine greater than 8.0 mg/dl (6.0 greater than mg/dl for diabetes)

(III) Glomerular filtration rate (GFR) less than 30 ml/min

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria:

(i) ***Chronic renal failure*** **(I), (II), or (III)** must be present~~)~~

(I) Creatinine clearance less than 10 cc/min (less than 15cc/min for diabetes)

(II) Serum creatinine greater than 8.0 mg/dl (6.0 greater than mg/dl for diabetes)

(III) Glomerular filtration rate (GFR) less than 30 ml/min

4. Reasons for Denial
   (i) Patients not meeting the specific medical criteria in this policy.
   (ii) Absence of supporting documentation of progression or rapid decline.
   (iii) Failure to document terminal status of six months or less.
   (iv) Patient is on dialysis.

Author: Wanda J. Davis, Associate Director, LTC Policy Advisory Unit, Long Term Care Division
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.26; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991. **Amended:** Filed March 20, 2001; effective June 20, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed February 17, 2006; effective May 16, 2006. **Amended:** Filed July 20, 2006; effective October 17, 2006.

Rule No. 560-X-51-.05. Election Procedures.

(1) If an individual meets the eligibility requirements for hospice care, he or she must file an election certification statement (Medicaid Hospice Election and Physician's Certification, Form 165) with a particular hospice. An election may also be filed by a representative as defined in Rule No. 560-X-51-.02(9).

(2) An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

(a) Remains in the care of a hospice.
(b) Does not revoke the election provisions under Rule No. 560-X-51-.07.
(c) Is recertified when there is a break in care.

(3) An individual or representative may designate an effective date that begins with the first day of hospice care or any subsequent day of hospice care. The two 90-day election periods must be used before the 60-day subsequent benefit periods. If an individual revokes the hospice election, any days remaining in that election period are forfeited.

(4) An individual or representative may not designate an effective date that is earlier than the date that hospice care begins.

(5) A Medicaid beneficiary who resides in a nursing home may elect hospice services. The hospice must have a contract with the nursing home to delineate which services each has responsibility to provide. A contract is necessary to clarify the details of how the nursing home and hospice will work together.

(6) If an individual is eligible for Medicare as well as Medicaid, the Medicare election form will serve as election for both hospice programs. If an individual eligible for Medicare and Medicaid enters the nursing home, is discharged from the nursing home to the hospital, is readmitted to the nursing home following hospitalization, is discharged from the nursing home to the community, or expires; the hospice provider must complete and return the Change in Status of Hospice Recipient, Form 165B, to the Medicaid Agency or its designee.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.24; State Medicaid Manual; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991. Emergency Rule effective May 15, 1991. Amended August 14, 1991 and October 1, 1993. **Amended:** Filed March 20, 2002; effective June 14, 2002. **Amended:** Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed February 17, 2006; effective May 16, 2006. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-51-.06. Waiver of Other Benefits.

An individual shall waive all rights to Medicaid services that are covered under Medicare for the duration of the election of hospice care for the following services:

(1) Hospice care provided by a hospice other than the hospice designated by the recipient, unless provided under arrangements made by the designated hospice

(2) Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or services that are equivalent to hospice care except for services:

(a) Provided by the designated hospice
(b) Provided by another hospice under arrangements made by the designated hospice.
(c) Provided by the individual's attending physician if that physician is not an employee of the designated hospice and does not receive compensation from the hospice for those services.

(3) Medicaid covered services that are not related to the hospice recipient's terminal illness are not waived.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.24; OBRA '90; State Medicaid Manual; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991. Effective date of this amendment October 1, 1993.
Amended: Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-51-.07. Election Revocation.

(1) An individual or representative may revoke the individual's election of hospice care at any time during an election period. If an individual revokes the hospice election, any days remaining in that election period are forfeited.

(2) The hospice shall provide the Alabama Medicaid Hospice Care Program a copy of the form used to revoke the individual's election for Medicaid coverage of hospice care for the remainder of that election period.

(3) Upon revocation of the election of Medicaid coverage of hospice care, an otherwise Medicaid eligible recipient resumes Medicaid coverage of the benefits waived when hospice care was elected.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.28; State Medicaid Manual; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991.

Rule No. 560-X-51-.08. Change of Hospice.

(1) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not a revocation of the election for the period in which it is made.

(2) To change the designation of hospice provider, the individual or representative must file a signed statement that includes the following information:

(a) The name of the hospice from which care has been received.
(b) The name of the hospice from which the individual plans to receive care.
(c) The effective date of the change.

A copy of this statement must be provided to the hospice provider and to the Alabama Medicaid Agency.

(3) The waiver of rights as address in Rule No. 560-X-51-.06 remains in effect.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.30; State Medicaid Manual; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-51-.09. Covered Services.

(1) The following services are covered hospice services when provided by qualified personnel:

(a) Nursing care
(b) Medical social services
(c) Physician services
(d) Counseling services
(e) Short-term inpatient care

(f) Medical appliances and supplies, including drugs and biologicals
(g) Home health aide services and homemaker services
(h) Physical therapy, occupational therapy, and speech-language pathology
(i) Nursing home room and board

(2) Nursing care, physician services, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician specialty services.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.80 and 42 CFR Section 418.202; State Medicaid Manual; and State Plan Attachment 3.1-A, pages 7.18 and 7.18a.
History: Rule effective February 13, 1991.

Rule No. 560-X-51-.10. Reimbursement for Levels of Care.

(1) With the exception of payment for direct patient care services by physicians, payment is made to the hospice for all covered services related to the treatment of the recipient's terminal illness for each day during which the recipient is Medicaid eligible and under the care of the hospice regardless of the amount of services furnished on any given day.

(2) Payment for hospice care must conform to the methodology and amounts calculated by the Centers for Medicare and Medicaid Services (CMS). Medicaid hospice payment rates are based on the same methodology used in setting Medicare rates and adjusted to disregard offsets attributable to Medicare coinsurance amounts. Each rate is a prospectively determined amount which CMS estimates generally equals the costs incurred by a hospice in efficiently providing hospice care services to Medicaid beneficiaries. The rates will be adjusted by Medicaid to reflect local differences in wages.

(3) With the exception of payment for physician services as outlined in Rule No. 560-X-51-.11, Medicaid reimbursement for hospice care will be made at one of four rates for each day in which a Medicaid recipient is under the care of hospice. The payment amounts are determined within each of the following categories:
(a) Routine home care. The hospice shall receive reimbursement for routine home care for each day the recipient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.
(b) Continuous home care. The hospice shall receive reimbursement for continuous home care when, in order to maintain the terminally ill recipient at home, nursing care is necessary on a continuous basis during periods of crises. Continuous home care is intended only for periods of crises where predominately skilled nursing care is needed on a continuous basis to achieve palliation or management of the recipient's acute medical symptoms; and only as necessary to maintain the recipient at home. A minimum of eight (8) hours per day must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.
(c) Inpatient respite care. The hospice shall receive reimbursement for inpatient respite care for each day that the recipient is receiving respite care. Patients admitted for this type of care are not in need of general inpatient care. Inpatient respite care may be provided only on an intermittent, non-routine, and occasional basis and may not be reimbursed for more than five consecutive days, including date of admission, but not date of discharge.
(d) General inpatient care. The hospice shall be reimbursed for general inpatient care for each day that the recipient is in an approved inpatient facility for pain control or acute or chronic symptom management. Payment for total inpatient care days (general or respite) for Medicaid patients cannot exceed twenty percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during each 12-month period of November 1 through October 31.

(4) Reimbursement for drugs not related to the recipient's terminal illness may be made to the dispensing pharmacy through the Medicaid Pharmacy Program.

(5) Reimbursement for disease specific drugs related to the recipient's terminal illness and drugs related to the terminal illness found on the Hospice Palliative Drug List (HPDL) are included in the per diem rates for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website at www.medicaid.alabama.gov.

(6) Medicaid will not restrict hospice services based on a patient's place of residence. If a beneficiary residing in a nursing home elects the Medicaid Hospice benefit, the Medicaid Program will pay the hospice directly an established rate in lieu of payments directly to the nursing home. The payment rate will be 95% of the rate Medicaid would have paid the nursing home directly for the same patient.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.302; State Medicaid Manual; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991. Amended: October 1, 1993. **Amended:** Filed March 20, 2001; effective June 20, 2001. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed April 20, 2007; effective August 1, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-51-.11. Reimbursement for Physician Services.

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. Group activities, which include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. Direct patient care services by physicians are reimbursed as follows:

(1) Payment for direct patient care services rendered by physicians employed by or working under arrangements made with the hospice may be billed by the physician with the hospice provider indicated as the payee. Services furnished voluntarily by physicians where the hospice has no payment liability are not reimbursable.

(2) Services provided by the patient's attending physician who is not an employee of, or receiving compensation from the hospice for services provided for the hospice, will be paid to that physician in accordance with the usual billing procedures for physicians.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.304; State Medicaid Manual; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991.

Rule No. 560-X-51-.12. Payment Acceptance.

(1) Payment made by the Medicaid program for hospice care services shall be considered payment in full.

(2) The patient or responsible party shall not be billed in full or in part for any service reimbursed under any service component of the Medicaid Hospice Care Program. Services that are not considered hospice care and non-covered Medicaid services may be billed to the individual.

(3) Co-payments may not be imposed with respect to hospice service rendered to Medicaid recipients.

(4) No person or entity, except a third party resource, shall be billed, in part or in full, for Medicaid covered services.

(5) For dually eligible recipients for whom Medicare is the primary payer for hospice services, Medicaid may be billed for coinsurance amounts for:

(a) Drugs and biologicals furnished by the hospice while the recipient is not an inpatient at 5% of the cost of the drug or biological not to exceed $5.00 per prescription.

(b) Inpatient respite care equal to 5% of the payment made by CMS for a respite care day.

Author: Priscilla Miles, Associate Director, LTC Program Management Unit.
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.400 and 418.402; State Medicaid Manual; and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991. Effective date of this amendment October 1, 1993.
Amended: Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-51-.13. Third Party Liability.

(1) A third party is another insurance company or agency that may be responsible for paying all or part of the cost for medical services provided to a Medicaid recipient. Some examples of third parties are Medicare, CHAMPUS, CHAMPVA, major medical insurance, dental insurance, cancer insurance, automobile insurance, and worker's compensation.

(2) Medicaid shall be considered the "payer of last resort." The hospice provider must bill all third parties which might pay for services provided before billing Medicaid.

(3) See Chapter 20, Third Party, for additional Third Party procedures.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.56(d); and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991.

Rule No. 560-X-51-.14. Confidentiality.

(1) The provider of hospice care shall not disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient, except upon the written consent of the recipient, his attorney, or his guardian, or upon subpoena from a court of appropriate jurisdiction. See Rule 560-X-20-.05, Third Party, for additional requirements regarding release of information.

(2) The hospice must safeguard the clinical record against loss, destruction, and unauthorized use.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.52 and 418.74(6)(b); and State Plan Attachment 3.1-A, page 7.18.
History: Rule effective February 13, 1991.

Rule No. 560-X-51-.15. Audits.

(1) The provider of hospice care shall furnish the Alabama Medicaid Hospice Care Program with requested information regarding claims submitted to the Medicaid Program and shall permit access to all Medicaid records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies.

(2) Complete and accurate medical and fiscal records that fully disclose the extent of the services and billings shall be maintained by the provider of hospice care. Said records shall be retained for the period of time required by state and federal laws.

Author: Hattie M. Nettles, Associate Director, LTC Policy Advisory Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR Section 418.74; and State Plan Attachment 3.18-A, page 7.18.
History: Rule effective February 13, 1991.

Chapter 52 - Home and Community-Based Living at Home (LH) Waiver for the Mentally Retarded

Rule No. 560-X-52-.01. Authority and Purpose.

(1) Home and community-based services for the mentally retarded or related conditions are provided by the Alabama Medicaid Agency to persons who are Medicaid-eligible under the waiver and who would, but for the provision of such services, require the level of care available in an intermediate care facility (ICF/MR) for the mentally retarded. These services are provided through a Medicaid waiver under provisions of the Omnibus Budget Reconciliation Act of 1981, which added Section 1915(c) to the Social Security Act, for an initial period of three years and renewal periods of five years.

(2) Home and community-based services covered in this waiver are In-Home Residential Habilitation, Day Habilitation, Prevocational Services, Supported Employment, Occupational Therapy, Speech and Language Therapy, Physical Therapy, Behavior Therapy, Respite Care, Personal Care Services, Personal Care Transportation, Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, Skilled Nursing, Community Specialist Services, and Crisis Intervention. These services provide assistance necessary to ensure optimal functioning of the mentally retarded or persons with related conditions.

(3) The Home and Community Based Living at Home Waiver is administered through a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and Mental Retardation and is restricted to individuals with a diagnosis of mental retardation or related condition, ages 3 and above, and those not residing in a group home situation. Priority access to the Living at Home Waiver shall be given to individuals on a verified waiting list.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.02. Description of Services.

Home and community-based services are defined as Title XIX Medicaid-funded services provided to mentally retarded individuals or persons with related conditions who, without these services, would require services in an ICF/MR. These services will provide health, social, and related support needed to ensure optimal functioning of the mentally retarded individual within a community setting. The operating agency may provide or subcontract for any services provided in this waiver. To qualify for Medicaid reimbursement each individual service must be necessary to prevent institutionalization. Each provider of services must have a signed provider contract, meet provider qualifications and comply with all applicable state and federal laws and regulations. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as waiver services. The specific services available as part of home and community-based services are:

(1) In-Home Residential Habilitation

(a) In-Home residential habilitation services provide care, supervision, and skills training in ADLs, home management and community integration.

(b) In-Home residential habilitation includes the following:

1. Habilitation training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities. Training and intervention may consist of incidental learning in addition to formal training plans, and will also encompass modification of the physical and/or social environment, meaning, changing factors that impede progress (i.e. moving a chair, substituting velcro

closures for buttons or shoe laces, changing peoples' attitudes toward the person, opening a door for someone, etc.) and provision of direct support, as alternatives to formal habilitative training.

2. Habilitation supplies and equipment; and

3. Transportation costs to transport individuals to day programs, social events or community activities, when public transportation or transportation covered under the Medicaid state plan is not available, accessible or desirable due to the functional limitations of the client, will be included in payments made to providers of residential habilitation. Residential Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service.

(c) Residential habilitation services are provided to recipients in their own homes, but not in group homes or other facilities.

(d) A unit of service is one hour. The place of service will primarily be the person's home, but may include services in the community to promote opportunities for inclusion, socialization, and recreation.

(e) In-Home residential habilitation goals must relate to identified, planned goals. Training and supervision of staff by a Qualified Mental Retardation Professional (QMRP) shall assure the staff is prepared to carry out the necessary training and support functions to achieve these goals. Initial training requirements must be met prior to the staff beginning work. Additional training to specifically address and further the goals in the individual's plan may occur on the job. Consumers and family members shall be included in the planning, and shall be offered and encouraged to use the opportunity to participate in the training and supervision of the staff.

(f) In-Home residential habilitation excludes the following:

1. Services, directly or indirectly, provided by a member of the individual's immediate family;

2. Routine care and supervision which would be expected to be provided by a family member;

3. Activities or supervision for which a payment is made by a source other than Medicaid; and

4. Room and board costs.

(g) Providers of residential habilitation must be certified by the Department of Mental Health and Mental Retardation.

(2) Day Habilitation

(a) Day habilitation includes planning, training, coordination, and support to enable and increase independent functioning, physical health and development, communication development, cognitive training, socialization, community integration, domestic and economic management, behavior management, responsibility and self direction. Staff may provide assistance/training in daily living activities and instruction in the skills necessary for independent pursuit of leisure time/recreation activities. Social and other adaptive skills building activities such as expressive therapy, prescribed use of art, music, drama or movement may be used to modify ineffective learning patterns and/or influence change in behavior.

(b) The provider for Day Habilitation services can be reimbursed based on eight levels of services.

(c) Transportation cost to transport individuals to places such as day programs, social events or community activities when public transportation and/or transportation covered under the State Plan is not available, accessible or desirable due to the functional limitations of the client, will be included in the rate paid to providers for this service. Day Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service. Providers of day habilitation must be certified by the Department of Mental Health and Mental Retardation.

(3) Prevocational Services

(a) Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

(b) When compensated, individuals are paid at less than 50 percent of the minimum wage.

(c) Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

(d) Providers of prevocational services must be certified by the Department of Mental Health and Mental Retardation.

(e) Prevocational services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401[16] and [17]).

(4) Supported Employment

(a) Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

(b) Supported employment is conducted in a variety of settings, particularly, work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

(c) When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities. Payment for the supervisory activities rendered as a normal part of the business setting will not be made.

(d) Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

(e) Medicaid reimbursement shall not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

(f) Payments for vocational training that is not directly related to an individual's supported employment program.

(g) Transportation will be provided between the individual's place of residence and the site of the habilitation services or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

(h) Providers of supported employment must be certified by the Department of Mental Health and Mental Retardation.

(5) Occupational Therapy

(a) Occupational therapy is the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. Occupational therapy services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure and/or obtain necessary functioning.

(b) Therapists may also provide consultation and training to staff or caregivers (such as client’s family and /or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

(c) Services must be prescribed by a physician and be provided on an individual basis. The need for service must be documented in the case record. Services must be listed on the care plan and be provided and billed by the hour. Occupational therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(d) Providers of service must maintain a service log that documents specific days on which occupational therapy services were delivered.

(6) Speech and Language Therapy

(a) Speech and language therapy are diagnostic, screening, preventive, corrective services provided on an individual basis, when referred by a physician (M.D., D.O.).

(b) These services may include:

1. Screening and evaluation of individuals' speech and hearing functions and comprehensive speech and language evaluations when so indicated;

2. Participation in the continuing interdisciplinary evaluation of individuals for purposes of implementing, monitoring and following up on individuals' habilitation programs; and

3. Treatment services as an extension of the evaluation process that include:

(i) Consulting with others working with the individual for speech education and improvement,

(ii) Designing specialized programs for developing an individual's communication skills comprehension and expression.

(c) Therapists may also provide training to staff and caregivers (such as a client's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

(d) Speech and language therapy services must be listed on the care plan and prescribed by a physician. The need for service must be documented in the case record. Services shall be provided and billed by the hour. Speech and language therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(e) Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered.

(7) Physical Therapy

(a) Physical therapy is physician-prescribed treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Physical therapy services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs that are designed to:

1. Preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and

2. Prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

(b) Therapists may also provide consultation and training to staff or caregivers (such as client's family and/or foster family).

(c) Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

(d) Documentation in the case record must justify the need for this service. Services must be listed on the care plan and be provided and billed by the hour. Physical therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

(e) Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered.

(8) Behavior Therapy

(a) Behavior Therapy Services provide systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP, for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation,

self direction or community integration, whose health is at risk, and/or who may otherwise require movement to a more restrictive environment. Behavior therapy may include consultation provided to families, other caretakers, and habilitation services providers. Behavior therapy shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior.

(b) A behavior management plan may only be used after positive behavioral approaches have been tried, and its continued use must be reviewed and re-justified in the case record every thirty (30) days. The unit of service is 15 minutes.

(c) The Behavior Therapy waiver service is comprised of two general categories of service tasks. These are (1) development of a BSP and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

(d) The two professional service provider levels are distinguished by the qualifications of the therapist. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform behavior therapy tasks. There is a different code and rate for each of the three service provider levels.

(e) Providers of service must maintain a service log that documents specific days on which services are delivered. Group therapy will not be reimbursed.

(f) The maximum units of service per year of both professional and technician level units combined cannot exceed 600 and the maximum units of service of professional level cannot exceed 400.

(9) Respite Care

(a) Respite care is a service provided in or outside a family's home to temporarily relieve the unpaid primary caregiver. Respite care provides short-term care for a brief period of rest or relief for the family from day-to-day care giving.

(b) Respite is intended for participants whose primary caregivers typically are the same persons day after day (e.g. family members and/or adult family foster care providers), and is provided during those portions of the day when the caregivers typically provide care. Relief needs of hourly or shift staff workers will be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care. Respite care typically is scheduled in advance, but it can also serve as relief in a crisis situation. In an instance of crisis relief, out-of-home respite can also allow time and opportunity for assessment, planning and intervention to try to re-establish the person in their home, or if necessary, to locate another home for them.

(c) Some consumers are institutionalized because their community supports become exhausted, or because they are unsure of how to cope with an increasingly challenging behavior, or due to the loss/incapacitation of a caregiver. The scope of out of home respite will allow quick response to place the person in an alternate setting and provide intensive evaluation and planning for return, with or without additional intervention and supports. Planning will be made for alternate residential supports if return is not possible.

(d) Respite care is dependent on the individual's needs as set forth in the plan of care and requires approval by the Division of Mental Retardation, subject to review by the Alabama Medicaid Agency. The limitation on either in-home or out-of-home respite care shall be 1080 hours or 45 days per waiver participant per waiver year.

(e) Out-of-home respite care may be provided in a certified group home or ICF/MR. In addition, if the recipient is less than 21 years of age, out-of-home respite care may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out-of-home respite, no additional Medicaid reimbursement will be made for other services in the institution.

(f) Medicaid reimbursement shall not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

(10) Personal Care Services

(a) Personal care services provide assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, routine care of adaptive equipment primarily involving cleaning as needed, meal preparation, assistance with eating, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation, and leisure activities. Assistance with IADLs includes accompaniment, coaching and minor problem-solving necessary to achieve the objectives of increased independence, productivity and inclusion in the community.

(b) Personal care under the Living at Home Waiver may also include general supervision and protective oversight reasonable to the accomplishment of health, safety and inclusion. The worker may directly perform some activities and support the client in learning how to perform others; the planning team (composed at minimum of the person and family, and a case manager or community specialist) shall determine the composition of the service and assure it does not duplicate, nor is duplicated by, any other service provided to the individual.

(c) A written description of what the personal care worker will provide to the person is required to be submitted to the state as part of or in addition to the plan of care, and will require approval by the Division of Mental Retardation and be subject to review by the Single State Agency for Medicaid.

(d) While in general, personal care will not be approved for a person living in a group home or other residential setting, the Division of Mental Retardation may approve it for specific purposes that are not duplicative.

(e) The plan of care or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Parents and other caretakers shall be key informers on the matter of special training, and will be encouraged to participate in the training and supervision of the worker.

(f) When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's documented need for the service as an alternative to institutional care and the reasonable cost effectiveness of his or her plan.

(g) There is no restriction on the place of service so long as the person is eligible for the waiver in that setting and no duplication of payment occurs. This would preclude personal care being provided in, for instance, a day habilitation or respite setting where payment would already be made for the same services. Payment is for an hour of service, not including worker's time of travel to and from the place of work.

(h) Personal Care Workers shall not be members of the immediate family (parents, spouses, children or siblings) of the person being supported, nor may they be legally obligated in any other way to provide the service. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered. Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency.

(i) Effective October 1, 2006, personal care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. This service must be billed under a separate code to distinguish it from other personal care activities.

(11) Personal Care Transportation

(a) Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of the personal care service. In order for this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. The Personal Care Transportation service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in *People First* and other community building activities. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported.

(b) The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer.

(c) Personal Care Transportation shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

(12) Environmental Accessibility Adaptations

(a) Environmental accessibility adaptations will provide physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization.

(b) Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems needed to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are of general utility and not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

(c) The individual's home may be a house or an apartment that is owned, rented or leased. Adaptations to the work environment covered by the Americans with Disabilities Act, or those that are the responsibility of other agencies, are not covered. Covered adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible.

(d) Total costs of environmental accessibility adaptations shall not exceed $5,000 per waiver year, per individual.

(13) Specialized Medical Equipment and Supplies

(a) Specialized medical equipment and supplies are devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

(b) This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the Medicaid State plan.

(c) Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.

(d) All items shall meet applicable standards of manufacture, design and installation. Costs are limited to $5,000 per waiver year, per individual.

(14) Skilled Nursing

(a) Skilled nursing services are services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

(b) Skilled nursing services consist of nursing procedures that meet the person's health needs as ordered by a physician.

(c) Skilled nursing services will be billed by the hour. There is no restriction on the place of service.

(15) Community Specialist Services

(a) Community Specialist Services are professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service

outcomes. The functions outlined for this service differs from case management in that these functions will incorporate person-centered planning, whereas case management does not.

(b) The provider must meet QMRP qualifications and be free of any conflict of interest with other providers serving the consumer. A community specialist with expertise in person centered planning may also be selected by the consumer to facilitate the interdisciplinary planning team meeting.

(c) Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

(d) The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver.

(e) The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management. If the consumer or family chooses to have the community specialist remain involved for a longer period of time, the targeted case manager will need only visit the person every 180 days, and call the person at 90-day intervals to ensure services actually are being delivered and are satisfactory.

(f) The community specialist will share information with the case manager quarterly in an effort to remain abreast of the client's needs and condition.

(g) A community specialist who facilitates the planning meeting for a person shall not have any conflict of interest with any provider who may wish to serve the person.

(h) This service is a cost effective and necessary alternative to placement in an ICF-MR. A unit of service is one hour.

(16) Crisis Intervention

(a) Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

(b) Crisis intervention may be provided in any setting in which the consumer resides or participates in a program. The service includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

(c) Crisis intervention will respond intensively to resolve crisis situations and prevent the dislocation of the person at risk such as individuals with mental retardation who are occasionally at risk of being moved from their residences to institutional settings because of family's inability to cope with short term, intense crisis situations. This service is a cost effective alternative to placement in an ICF-MR.

(d) Crisis intervention services are expected to be of brief duration (8 weeks, maximum). When services of a greater duration are required, the individual shall be transitioned to a more appropriate service program or setting.

(e) Crisis intervention services require two levels of staff, professional and technician.

(f) A unit of service is one hour and must be provided by the waiver planning team, directed by a graduate psychologist or licensed social worker.

(g) When the need for this service arises, the service will be added to the plan of care for the person.

(h) A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided.

(i) All crisis intervention services shall be approved by the regional community service office of the DMH/MR prior to the service being initiated.

(j) Crisis intervention services will not count against the $25,000 per person per year cap in the waiver, since the need for the service cannot accurately be predicted and planned for ahead of time.

(k) Specific crisis intervention service components may include the following:

1. Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;

2. Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;

3. Developing and writing an intervention plan;
4. Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
5. Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;
6. Assisting the consumer with self care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situation; and
7. Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.

Author: Monica Abron, Administrator, LTC Program Management Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002. **Amended:** Filed March 20, 2007; effective June 15, 2007. **Amended:** Filed November 17, 2008; effective February 11, 2009.

Rule No. 560-X-52-.03. Eligibility.

Medical eligibility is limited to those individuals who meet the ICF/MR facility level of care. No waiver services will be provided to a recipient residing in an institutional facility, or who has a primary diagnosis of mental illness, or whose health and safety is at risk in the community. Thus services will be available to the mentally retarded (MR) and persons with related conditions who would be eligible for institutional services under 42 CFR 435.217.

Financial eligibility is limited to the following individuals:

- Individuals receiving SSI.
- SSI related protected groups deemed to be eligible for SSI/Medicaid.
- Medicaid for Low Income Families (MLIF).
- Federal and State adoption subsidy individuals.

MR persons who meet categorical (including 42 CFR 435.120) medical and/or social requirements for Title XIX coverage will be eligible for home and community-based services under the waiver. Applicants found eligible shall not be required to apply income above the personal needs allowance reserved to institutional recipients toward payment of care.

Author: Monica Abron, Administrator, LTC Program Management Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002. **Amended:** Filed November 17, 2008; effective February 11, 2009.

Rule No. 560-X-52-.04. Characteristics of Persons Requiring ICF/MR Care.

(1) Generally, persons eligible for the level of care provided in an ICF/MR are those persons who need such level of care because the severe, chronic nature of their mental impairment results in substantial functional limitations in three or more of the following areas of life activity:

- Self Care
- Receptive and expressive language
- Learning

- Self-direction
- Capacity for independent living
- Mobility

(2) Services provided in an intermediate care facility for the mentally retarded in Alabama are those services that provide a setting appropriate for a functionally mentally retarded person in the least restrictive productive environment currently available. Determination regarding eligibility for ICF/MR care is made by a Qualified Mental Retardation Professional (QMRP). A QMRP is an individual possessing, at minimum, those qualifications in 42 C.F.R. Section 442.401. Recommended continued stay is made by an interdisciplinary team of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, and certified by a QMRP and a physician.

(3) ICF/MR care includes those services that address the functional deficiencies of the beneficiaries and that require the skills of a QMRP to either provide directly or supervise others in the provision of services needed for the beneficiary to experience personal hygiene, participate in daily living activities appropriate to his functioning level, take medication under appropriate supervision (if needed), receive therapy, receive training toward more independent functioning, and experience stabilization as a result of being in the least restrictive, productive environment in which he or she can continue his/her individual developmental process.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.05. Qualifications of Staff Who Will Serve As Review Team for Medical Assistance.

(1) The nurse shall be a graduate of a licensed school of nursing with a current state certification as a Licensed Practical Nurse (LPN) or Registered Nurse (RN). This person shall have knowledge and training in the area of mental retardation or related disabilities with a minimum of two (2) years' nursing experience.

(2) The social worker shall be a graduate of a four-year college with an emphasis in social work. This person shall have knowledge and training in the area of mental retardation or related disabilities with a minimum of two (2) years' social work experience.

(3) The psychologist shall be a Ph.D. in Psychology. This person shall be a licensed psychologist with general knowledge of test instruments used with the mentally retarded or related disabilities with a minimum of two (2) years' experience in psychology.

(4) Other professional disciplines which may be represented on the assessment team as necessary depending on the age, functional level, and physical disability of the clients are as follows:

(a) Special Education,
(b) Speech Pathologist,
(c) Audiologist,
(d) Physical Therapist,
(e) Optometrist,
(f) Occupational Therapist,
(g) Vocational Therapist,
(h) Recreational Specialist,
(i) Pharmacist,
(j) Doctor of Medicine,

(k) Psychiatrist, and
(l) Other skilled health professionals

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.06. Financial Accountability.

The financial accountability of providers for funds expended on home and community-based services must be maintained and provide a clearly defined audit trail. Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients through the renewal period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the State of Alabama, the provider will pay all travel costs of the auditors to the location of the records.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.07. Individual Assessments.

(1) Alabama Medicaid Agency will require an individual plan of care for each waiver service recipient. Such plan, entitled "Individual Habilitation Plan" (IHP), is subject to review by the Alabama Medicaid Agency and Department of Health and Human Services. The Alabama Medicaid Agency will review recipients' habilitation and care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures. Client assessment procedures in place in the Alabama Department of Mental Health and Mental Retardation, which are based on eligibility criteria for ICF/MRs developed jointly by DMH/MR and the Alabama Medicaid Agency, will be utilized by the Department of Mental Health and Mental Retardation (or its contract service providers) in screening for eligibility for the waiver services as an alternative to institutionalization. Whether performed by a qualified practitioner in the Department of Mental Health and Mental Retardation, its contract service providers, or provided by qualified (Diagnostic and Evaluation Team) personnel of the individual/agency arranging the service, review for "medical assistance" eligibility determination will be based on client assessment data, and the criteria for admission to an ICF/MR, as described in Rule No. 560-X-35-.03. Re-evaluation of clients shall be performed on an annual basis. Written documentation of all assessments will be maintained in the client's case file and subject to review by the Alabama Medicaid Agency and Department of Health and Human Services.

(2) The Alabama Medicaid Agency will give notice of services available under the waiver as required by federal regulations, particularly to primary care givers for the target group, including but not limited to, programs operated by Alabama Department of Mental Health and Mental Retardation, the statewide network of community MH/MR centers, and to other appropriate care-giving agencies such as county Department of Human Resources offices, hospitals, hospital associations, and associations for the mentally retarded.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.08. Informing Beneficiaries of Choice.

(1) Alabama Medicaid Agency will be responsible for assurances that beneficiaries of the waiver service program will be advised of the feasible service alternatives and be given a choice of which type of service–institutional or home- and/or community-based services–they wish to receive.

(2) Residents of long-term care facilities for whom home and community-based services become a feasible alternative under this waiver will be advised of the available alternative at the time of medical review. Applicants for SNF, ICF, ICF/MR services, or a designated responsible party with authority to act on the applicant's behalf, will be advised of feasible alternatives to institutionalization at the time of their entry into a treatment system wherein an alternative is professionally determined to be feasible. All applicants found eligible will be offered the alternative unless there is reasonable expectation that services required for the applicant would cost more than institutional care. Provisions for fair hearings for all persons eligible for services under this waiver will be made known and accessible to potential eligibles in accordance with Fair Hearings Procedures in place in the Alabama Medicaid Program.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.09. Payment Methodology for Covered Services.

(1) Actual reimbursement will be based on the rate in effect on the date of service.

(2) Rates will be established and reported to the Alabama Medicaid Agency's fiscal agent for claims submitted for payment.

(3) Payment will be based on the number of units of service reported for each HCPC code.

(4) All claims for services must be submitted within one year from the date of service.

(5) Accounting for actual cost and units of services provided during a waiver year must be captured on the HCFA 372 Report.

Author: Patricia Harris, Administrator, LTC Program Management Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002. **Amended:** Filed August 20, 2004; effective November 16, 2004.

Rule No. 560-X-52-.10. Payment Acceptance.

(1) Payment made by the Medicaid Program to a provider shall be considered to be payment in full for covered services rendered.

(2) No Medicaid recipient shall be billed for covered Medicaid services for which Medicaid has been billed.

(3) No person or entity, except a liable third party source, shall be billed for covered Medicaid services.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.11. Confidentiality.

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon the written consent of the recipient, his/her attorney, or his/her guardian, or upon subpoena from a court of appropriate jurisdiction.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.12. Records.

(1) The Department of Mental Health and Mental Retardation shall make available to the Alabama Medicaid Agency at no charge, all information regarding claims submitted and paid for services provided eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. Complete and accurate medical/psychiatric and fiscal records which fully disclose the extent services shall be maintained by the clinic. Said records shall be retained for the period of time required by state and federal laws.

(2) A sign-in log complete with the date and nature of services provided must be signed by the recipient. If the recipient is unable to sign, the signature must be obtained by the responsible guardian/caregiver.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.13. Provider Enrollment.

(1) Medicaid's fiscal agent enrolls providers of waiver services and issues provider agreements to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations and the *Alabama Medicaid Provider Manual*.

(2) General enrollment instructions and information can be found in Chapter 2, "Becoming a Medicaid Provider", of the *Alabama Medicaid Provider Manual*. Failure to provide accurate and truthful information or intentional misrepresentation may result in action ranging from denial of application to permanent exclusion.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 431, Subpart E–Fair Hearings for Applicants and Recipients.
History: New Rule: Filed September 20, 2002; effective December 2002.

Rule No. 560-X-52-.14. Cost for Services.

(1) The cost for services to individuals who qualify for home and community-based care under the waiver program will not exceed a cap of $25,000 per client per year with the exception that crisis intervention services are not included in the cap. Further, the waiver program will not exceed on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

Author: Monica Abron, Administrator, LTC Program Management Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed September 20, 2002; effective December 26, 2002. **Amended:** Filed November 17, 2008; effective February 11, 2009.

Rule No. 560-X-52-.15. Fair Hearings.

(1) An individual who is denied home and community-based services based on Rule No. 560-X-52-.03, may request a fair hearing in accordance with 42. C.F.R. 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code.

(2) Recipients will be notified in writing at least ten days prior to termination of service.

(3) A written request for a hearing must be received by Medicaid within sixty (60) days following the date on the notice of action with which an individual is dissatisfied.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 431, Subpart E–Fair Hearings for Applicants and Recipients.
History: New Rule: Filed September 20, 2002; effective December 26, 2002.

Rule No. 560-X-52-.16. Application Process.

(1) The Alabama Medicaid Agency will provide the operating agency with the approved level of care determination process.

(2) Financial eligibility is limited to those individuals receiving SSI.

(3) The QMRP will complete the level of care determination and the plan of care development.

(4) The operating agency is required to adhere to all federal and state guidelines in the determination of the level of care approval.

(5) The applicant's physician must certify that "without waiver services the client is at risk of institutionalization."

(6) The operating agency or its designee (case manager), will ensure that the applicant has been screened and assessed to determine if the services provided through the LAH Waiver will meet the applicant's needs in the community.

(7) The Alabama Department of Mental Health and Mental Retardation (ADMH/MR) is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community based services in accordance with the provisions of the Living at Home Waiver.

(8) The Alabama Medicaid Agency will provide to the ADMH/MR the approved Level of Care criteria and policies and procedures governing the level of care determination process.

(9) The ADMH/MR will designate a qualified medical professional to approve the level of care and develop the Plan of Care.

(10) Admissions and readmissions for clients who have not received services for the previous six (6) month period must be certified by a physician licensed to practice in Alabama.

(11) ADMH/MR may utilize Medicaid staff for consultation on questionable admissions and annual redeterminations prior to a final decision being rendered.

(12) The Alabama Medicaid Agency will conduct a retrospective review on a monthly basis of a 10% sample of individuals served under the Living at Home Waiver to determine appropriate admissions and annual redeterminations. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met. The Waiver Quality Assurance Unit conducts a 5% sample of plans of care and related documents annually for each provider.

(13) The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal, medical necessity, and eligibility requirements are not met.

(14) The Alabama Medicaid Agency may seek recoupment from ADMH/MR for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for the Living at Home Waiver services or Medicaid eligibility but for the certification of waiver eligibility by ADMH/MR.

(15) The operating agency or its designee will develop a plan of care that includes waiver as well as non-waiver services.

(16) Upon receipt of the financial award letter from the Alabama Medicaid Agency, the LTC Admissions Notification Form should be completed and forwarded to Medicaid's Fiscal Agent electronically. Medicaid's Fiscal Agent will either accept or reject the transmission of the LTC Admissions Notification Form. The operating agency or its designee will receive notice of the status of applications transmitted the next business day following the transmission.

(17) If Medicaid's Fiscal Agent accepts the transmission, the information is automatically written to the Long Term Care file (RW). The operating agency or its designee can begin rendering services and billing the Alabama Medicaid Agency for services rendered.

(18) If Medicaid's Fiscal Agent rejects the transmission, the operating agency or its designee must determine the reason for the rejection and retransmit the LTC Admissions Notification Form.

(19) Neither the Alabama Medicaid Agency nor Medicaid's Fiscal Agent will send out the LTC-2 Notification letters. The record of successful transmission will be the record of "approval" to begin rendering service.

(20) For applications where the level of care is questionable, providers may submit the applications to the Long Term Care Admissions/Records Unit for review by a nurse and/or a Medicaid physician.

(21) Once the individual's information has been added to the Long Term care File (RW), changes can only be made by authorized Medicaid staff.

Author: Samantha McLeod, Administrator, LTC Program Management Unit

Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G–Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed May 20, 2003; effective August 18, 2003. **Amended:** Filed March 20, 2007; effective June 15, 2007.

Chapter 53. Reserved.

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Chapter 54 - Home and Community-Based Services for Individuals under the Technology Assisted (TA) Waiver for Adults

Rule No. 560-X-54-.01. Authority and Purpose.

(1) Home and community-based services for the Technology Assisted Waiver for Adults are provided by the Alabama Medicaid Agency to individuals with disabilities who would otherwise require institutionalization in a nursing facility. These services are provided through a Medicaid waiver under the provisions of Section 1915(c) of the Social Security Act for an initial period of three (3) years and for five (5) year periods thereafter upon renewal of the waiver by the Centers for Medicare and Medicaid Services (CMS).

(2) The purpose of providing home and community-based services to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care.

Author: Felecia S. Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 CFR Section 441, Subpart G. **History:** Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-54-.02. Eligibility.

(1) Financial eligibility is limited to those individuals receiving SSI and optional categorically needy at a special income level of 300 percent of SSI.

(2) Medical eligibility is determined based on current admission criteria for nursing facility level of care as described in Rule No. 560-X-10-.10. In addition, waiver services are limited to those individuals who received private duty nursing services through the Early Periodic Screening Diagnostic Testing (EPSDT) Program under the Alabama Medicaid State Plan who will no longer be eligible for this service upon turning age 21 and for whom private duty nursing services continue to be medically necessary based upon approved private duty nursing criteria outlined in the approved waiver document.

(3) No waiver services will be provided to recipients in a hospital or nursing facility.

(4) The Alabama Medicaid Agency may also deny home and community-based services if it is determined that an individual's health and safety is at risk in the community; if the individual does not cooperate with a provider in the provision of services; or if an individual fail to meet the goals and objectives of being on the waiver program.

(5) The Alabama Medicaid Agency is restricted by the waiver to serving the estimated annual unduplicated number of beneficiaries approved by the Centers for Medicare and Medicaid Services.

(6) The eligibility age criteria is 21 years and above.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-54-.03. Covered Services.

(1) Personal Care/Attendant Services.

(a) Personal Care/Attendant Service (PC/AS) provides in-home and out-of-home (job site) assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair and vice versa, ambulation, maintaining continence, medication management and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as, laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

(b) PC/AS is designed to increase an individual's independence and ability to perform daily activities and to support individuals with physical disabilities in need of these services as well as those seeking or maintaining competitive employment either in the home or an integrated work setting.

(c) PC/AS is not an entitlement. It is based on the needs of the individual client as reflected in the Plan of Care.

(2) Private Duty Nursing.

(a) The Private Duty Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform his/her duties in compliance with the Nurse Practice Act and the Alabama State Board of Nursing. Private Duty Nursing under the waiver will not duplicate Skilled Nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Private Duty Nursing under the waiver is utilized.

(b) Private Duty Nursing Services are not an entitlement. They are based on the needs of the individual client as reflected in the plan of care.

(3) Medical Supplies.

(a) Medical supplies and appliances includes devices, controls, or appliances specified in the Plan of Care, not presently covered under the State Plan, which enable the individual to increase his/her abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he/she lives. All waiver medical supplies and appliances must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. Medical supplies and appliances do not include over-the-counter personal care items such as toothpaste, mouthwash, soap, cotton swabs, Q-tips, etc. Items reimbursed with waiver funds will be in addition to any medical supplies furnished under the State Plan and exclude those items which are not of direct medical or remedial benefit to the individual.

(b) Providers of this service will be only those who have signed provider agreements with the Alabama Medicaid Agency.

(c) Medical supplies and appliances are limited to $1,800 per client per waiver year. Documentation of items purchased will be maintained by the targeted case manager. An additional amount above that of $1,800 may be requested by the client and prior approved by Medicaid if medically necessary.

(4) Assistive Technology.

(a) Assistive Technology includes devices, pieces of equipment or products that are modified, customized and used to increase, maintain or improve functional capabilities of individuals with disabilities as specified in the Plan of Care. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology device. Such services may include acquisition, selection, design, fitting, customizing, adaptation, application, etc. Items reimbursed with waiver funds exclude items which are not of direct medical benefit to the recipient. Receipt of this service must be based upon medical necessity to prevent institutionalization as documented in the medical record and all items must meet applicable standards of manufacture, design and installation.

(b) The amount for this service is $20,000 per client. Any expenditure in excess of $20,000 must be approved by the Alabama Medicaid Agency. All assistive technology items must be ordered by a physician, documented on the Plan of Care and must be prior authorized and approved by the Alabama Medicaid Agency.

(c) To obtain prior authorization numbers for this service, the case manager must submit a copy of the following documents to the Alabama Medicaid Agency (AMA):

1. Medicaid Prior Authorization Form;
2. An agreement between the AMA and the company providing the service;
3. A price quotation list from the company supplying the equipment, providing a description of the item; and
4. A legible copy of the physician's prescription for the item.

(d) Upon completion of service delivery, the client or their legal representative must sign and date acknowledging satisfaction with the service.

(e) Providers of assistive technology shall be capable of supplying and training in the use of assistive technology devices.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-54-.04. Costs for Services.

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

Author: Felecia S. Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-54-.05. Application Process.

(1) The Alabama Department of Rehabilitation Services targeted case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community-based services.

(2) An assessment document will be completed by the targeted case manager in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the Alabama Medicaid Agency for approval.

(3) The targeted case manager, in conjunction with the applicant's physician will develop a plan of care. The plan of care will include objectives, services, provider of services, and frequency of service. The plan of care must be submitted to the Alabama Medicaid Agency for approval. Changes to the original plan of care are to be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's plan of care, which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the targeted case manager as often as necessary and administered in coordination with the recipient's physician.

(4) The targeted case manager will coordinate completion of the medical need admissions form with the applicant's physician and the financial application form for submission to the Alabama Medicaid Agency's Long Term Care (LTC) Policy Advisory Unit.

(5) The LTC Policy Advisory Unit will review the medical application and determine if the individual meets the criteria for nursing facility care, in accordance with Rule No. 560-X-10-.10 of the Alabama Medicaid Administrative Code and submit the "Waiver/Slot Confirmation Form" to the District Office for processing financial determination.

(a) If approved, the applicant and the targeted case manager will be notified in writing.

(b) If denied, the applicant and the targeted case manager will be notified and the reconsideration process will be explained in writing as described in Rule No. 560-X-10-.14.

(6) When an application is approved by the Alabama Medicaid Agency, a payment date is also given for the level of care for which a recipient has been approved. No charges for services rendered under the Waiver Program prior to this approved payment date will be paid.

(7) A current assessment document, along with a new plan of care, and medical need admission form must be submitted by the targeted case manager to the Alabama Medicaid Agency at each re-determination of eligibility which shall be at least every six months.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-54.-06. Fair Hearings.

(1) An individual whose application to the Waiver Program is denied based on Rule No. 560-X-54-.02 may request a hearing through the appropriate operating agency, or the Alabama Medicaid Agency.

(2) An individual who is denied home and community-based services based on Rule No. 560-X-54-.02, may request a fair hearing in accordance with 42 CFR Section 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code.

(3) Applicants will be given at least a ten-day notice before termination of service.

(4) A written request for a hearing must be received by Medicaid within 60-days following notice of action for which an individual is dissatisfied.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-54-.07. Payment Methodology for Covered Services.

(1) Payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

(2) For each recipient, the claim will allow span billing for a period up to one (1) month. There may be multiple claims in a month; however no single claim can cover services performed in different months. For example, claims with dates of service of 2/22/03 to 3/22/03 would not be allowed. If the submitted claim covers dates of service where part, or all of which were covered in a previously paid claim, the claim will be rejected.

(3) Payment will be based on the number of units of service reported on the claim for each procedure code.

(4) Accounting for actual cost and units of services provided during a waiver year must be captured on Centers for Medicare and Medicaid Services (CMS) Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

(a) A waiver year consists of 12 consecutive months starting with the approval date specified in the approved waiver document.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the state agency or the provider.

(c) The services provided by an operating agency are reported and paid by dates of service. Thus, all services provided during the 12 months of the waiver year will be attributed to that year.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Technology Assisted Waiver for Adults.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-54-.08. Confidentiality.

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon the written consent of the recipient, his/her attorney, or his/her guardian, or upon subpoena from a court of appropriate jurisdiction.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit
Statutory Authority: Section 1915(c), Social Security Act, 42 CFR Section 431.306.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-54-.09. Records.

(1) The Alabama Medicaid Agency shall maintain all information regarding claims submitted and paid for services provided eligible recipients. Said records shall be retained for the period of time required by state and federal laws.

(2) A sign-in log, service receipt, or some other written record shall be used to show the date and nature of services; this record shall include the Recipient's signature or designated signature authority.

(3) Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a three-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.

(4) There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The Alabama Medicaid Agency and Centers for Medicare and Medicaid Services and the operating agencies must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit
Statutory Authority: Section 1915(c), Social Security Act, 42 CFR Section 441, Subpart G.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-54-.10. Enrollment.

(1) Medicaid's fiscal agent enrolls providers of waiver services and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations and the *Alabama Medicaid Provider Manual*.

(2) General enrollment instructions and information can be found in Chapter 2, "Becoming a Medicaid Provider", of the *Alabama Medicaid Provider Manual*. Failure to provide accurate and truthful information or intentional misrepresentation may result in action ranging from denial of application to permanent exclusion and criminal prosecution.

Author: Felecia S. Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: Section 1915(c), Social Security Act, 42 CFR Section 441, Subpart G.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Rule No. 560-X-54-.11. Informing Individuals of Choice.

(1) The Alabama Medicaid Agency will be responsible for ensuring that beneficiaries of the waiver service program will be advised of the feasible service alternatives and be given a choice of which type of service—institutional or home- and/or community-based services—they wish to receive.

(2) Residents of long-term care facilities for whom home- and community-based services become a feasible alternative under this waiver will be advised of the available alternative at the time of review. Provisions for fair hearings for all persons eligible for services under this waiver will be made known and accessible to potential eligibles in accordance with Fair Hearings Procedures in place in the Alabama Medicaid Program.

Author: Felecia S. Barrow, Associate Director, LTC Project Development Unit
Statutory Authority: Section 1915(c), Social Security Act, 42 CFR Section 441, Subpart G.
History: Emergency Rule filed and effective March 13, 2003. **Amended:** Filed March 20, 2003; effective June 16, 2003.

Chapter 55. Perinatal Coordinators

Rule No. 560-X-55-.01. Authority and Purpose.

1. Perinatal coordinators serve as a liaison between the provider community, Medicaid eligible pregnant women and infants, the Department of Public Health and the Alabama Medicaid Agency. These services are provided through a cooperative agreement between Medicaid and the Department of Public Health.
2. The purpose of providing these services is to ensure availability of and access to care for the benefit of Medicaid eligible recipients.

Authority: 42 CFR, - 431.615, State Plan, Attachment 4.16-A. Effective date of this rule is January 14, 1992.

Rule No. 560-X-55-.02. Qualifications of a Perinatal Coordinator.

1. A Perinatal Coordinator must meet the requirements of a registered Nurse as defined by the State Personnel Department and will be governed by such rules and regulations. The Department of Public Health has the right to determine the nurse classification for each perinatal coordinator position. Perinatal coordinators reimbursed under this contract can only be employed by the Health Department.
2. Hiring practices will be accomplished by the Department of Public Health. Required performance reviews will be accomplished by the Perinatal Coordinators assigned supervisor within the Health Department.
3. The Department of Public Health will be responsible for assuring that the professionals who provide such services meet the requirements as outlined in the cooperative agreement and as outlined in the Administrative Code.
4. Medicaid reserves the right to ask for replacement of any individual perinatal coordinator who is found to be in violation of the terms of the contract.

Authority: 42 CFR, - 431.615, State Plan, Attachment 4.16-A. Effective date of this rule is January 14, 1992.

Rule No. 560-X-55-.03. Functions of Perinatal Coordinators.

1. Perinatal Coordinators are required to spend 80% of their billable time serving the needs of Medicaid eligible clients. Services included, but are not limited to, the following types of service:
   (a) Increasing the awareness of and utilization of tertiary care centers and preventative health care.
   (b) Evaluation of available resources, identification of areas of need, and the development of new resources in areas of identified need.
   (c) Research and development of a more effective mechanism for the transfer of high risk mothers and babies.
2. Perinatal Coordinators and their clerical support must keep a daily log of their activities. Activities recorded on the daily log and their performance standards and task statements, and evaluations will be the basis for computing billable time.
3. Perinatal Coordinators are required to submit a quarterly report to the Director, Perinatal Branch, Family Health Services, Department of Public Health.
4. Medicaid reserves the right to review daily logs, quarterly reports and any other pertinent documentation as necessary.

Authority: 42 CFR, - 431.615, State Plan, Attachment 4.16-A. Effective date of this rule is January 14, 1992.

Rule No. 560-X-55-.04. Auditing Procedures.

An annual audit will be conducted by the Medicaid Agency of each perinatal coordinator's activities. In addition, periodic audits may be performed by the Health Care Financing Administration.

Authority: 42 CFR, - 431.615, State Plan, Attachment 4.16-A. Effective date of this rule is January 14, 1992.

Rule No. 560-X-55-.05. Payment for services.

1. The Department of Public Health will be reimbursed their costs of providing these services as specified in the contract.
2. Skilled medical and professional costs will include the salary of perinatal coordinators, travel required in the performance of these duties, and any training required to effectively discharge their duties. This also includes clerical support. Administrative costs for services performed by perinatal coordinators and clerical support will also be reimbursed at a percentage appropriate to the type of services provided.
3. All invoices must be submitted by Public Health in accordance with guidelines established by Medicaid. Public Health agrees to accept as payment in full the amount paid by Medicaid for a covered item(s) and will make no additional charge or charges for a covered item(s) to a recipient/sponsor or family thereof.

Authority: 42 CFR, - 431.615, State Plan, Attachment 4.16-A. Effective date of this rule is January 14, 1992.

Chapter 56. Federally Qualified Health Center Reimbursement

Rule No. 560-X-56-.01. Federally Qualified Health Center Reimbursement- Preface.

This Chapter states the Medicaid policy regarding Federally Qualified Health Centers, hereinafter referred to as FQHCs, reimbursement and establishes the accepted procedures whereby reimbursement is made to FQHC providers. Because of the length and complexity of this Chapter, it has been divided into sections to facilitate its utilization.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.02. Introduction.

1. This Chapter of the Alabama Medicaid Administrative Code has been published by the Alabama Medicaid Agency (Medicaid) to accommodate program needs and the administrative needs of FQHCs and to help ensure that the reasonable cost regulations are uniformly applied state wide without regard to where covered services are furnished.
2. The Alabama Medicaid Program is administered by Medicaid under the direction of the Governor's Office. Reimbursement principles for FQHC's are outlined in the following sections of this Chapter. These principles, hereinafter referred to as "Medicaid Reimbursement Principles," are a combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and principles and procedures published by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated FQHC's. These principles are not intended to be all inclusive, and additions, deletions, and changes to them will be made by Medicaid as required. Providers are urged to familiarize themselves fully with the following information, as cost reports must be submitted to Medicaid in compliance with this Chapter and other provisions of the Medicaid Administrative Code.
3. If the Medicaid Administrative Code is silent on a given point, Medicaid will normally rely on appropriate OMB circulars (i.e., OMB A87, OMB 122, OMB 128, OMB 133), Medicare (Title XVIII) Principles of Retrospective Reimbursement and, in the event such Medicare Principles provide no guidance, Medicaid may impose other reasonability tests. The tests include, but are not limited to, such tests as:
   - (a) Does the cost as reported comply with generally accepted accounting principles?
   - (b) Is the cost reasonable on its own merit?
   - (c) How does the cost compare with that submitted by similarly sized centers furnishing like covered services?
   - (d) Is the cost related to covered services and necessary to the operation of a center?
4. It is recognized that there are many factors involved in operating an FQHC. Costs may vary from one facility to another because of scope of services, level of care, geographical location, and utilization. Considerable effort has been made to recognize such variables during the development of this Chapter. Only reported costs reflecting such variables without exceeding the "prudent buyer" concept or other applied tests of reasonability will be allowed by Medicaid. Implicit in the intention that actual costs be paid to the extent they are reasonable, is the expectation that the center seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer would pay for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

5. Records must be kept by the provider which document and justify costs, and only those costs which can be fully and properly substantiated will be allowed by Medicaid. Increases in costs per encounter over amounts reported on provider's previous cost reports, except those increases inherent in normal inflation, will be closely examined for reasonableness.
6. Unallowable costs which are identified during either desk audits or field audits will be disallowed despite similar costs having been included in prior cost reports without having been disallowed.
7. The only source of the funds expended by Medicaid is public funds, exacted from the taxpayers through state and federal taxes. Improper encroachment on these funds is an affront to the taxpayers and will be treated accordingly.
8. To assure only necessary expenditures of public money, it will be the policy of Medicaid to:
   (a) Conduct on-site audits of facilities on an unannounced basis, although prior announcement may be made at the discretion of Medicaid.
   (b) Determine audit exceptions in accordance with Medicaid Reimbursement Principles.
   (c) Allow only non-extravagant, reasonable, necessary and other allowable costs and demand prompt repayment of any unallowable amounts to Medicaid.
9. In the event desk audits or field audits by Medicaid's staff reveal that providers persist in including unallowable costs in their cost reports, Medicaid may refer its findings to the Medicaid Program Integrity Division, Medicaid Legal Counsel, and/or the Alabama Attorney General.
10. While the responsibility for establishing policies throughout the Medicaid Program rests with Medicaid, comments on the contents of this Chapter are invited and will be given full consideration.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.03. Definitions.

1. Accrual Method of Accounting - Revenues must be allocated to the accounting period in which they are earned and expenses must be charged to the period in which they are incurred. This must be done regardless of when cash is received or disbursed.
2. Chapter - This Chapter (Chapter Fifty-Six) of the Alabama Medicaid Agency Administrative Code.
3. Costs Not Related to Patient Care - Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs.
4. Costs Related to Patient Care - These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.
5. Covered Costs - Allowable direct and indirect costs that are reasonable and necessary in rendering covered health care services. To be recognized, costs (as indicated in the State Plan) must be identified in auditable accounting records and allocated on a reasonable basis between the delivery of covered type services and all other center activities.
6. Depreciation - That amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period of operation.
7. Encounters - Encounters are face-to-face contacts between a patient and a health professional for the provision of medically necessary services.
   (a) Ancillary Encounter - Face-to-face contact between a patient and a health professional for lab or x-ray services only.
   (b) Dental Encounter - Face-to-face contact between a patient and a health professional for the provision of dental services.
   (c) Medical Encounter - Face-to-face contact between a patient and a health professional for the provision of medical services (i.e., physician, physician assistant, nurse practitioner).
   (d) EPSDT, Family Planning, or Prenatal Encounter - Face-to-face contact to receive services within the parameters of the program guidelines.

8. Fair Market Value - The bona fide price at which an asset would change hands or at which services would be purchased between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having a reasonable knowledge of the relevant facts.
9. Federally Qualified Health Center - Facilities or programs which meet one of the following requirements:
    (a) receives a grant under Section 329, 330, or 340 of the Public Health Act;
    (b) meets the requirements for receiving such a grant as determined by the Secretary based on recommendations of the Health Resources and Services Administration within the Public Health Service; or
    (c) qualifies through waivers of the requirements described above as determined by the Secretary for good cause.
    (d) outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).
10. Fiscal Year - The 12 month period upon which providers are required to report their costs, also called the reporting period.
11. Fringe Benefits - Fringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death.
12. Full Time Equivalents (FTE) - The result of a calculation which determines the average number of employees per position working the customary work week full time.
13. HCFA - The Health Care Financing Administration, an agency of the U. S. Department of Health and Human Services.
14. HIM-15 - The title of the Medicare Provider Reimbursement Manual, a publication of HCFA.
15. Home Office Costs - See Rule 560-X-56-.12 for the in-depth discussion and treatment of home office costs.
16. Interest - Cost incurred for the use of borrowed funds.
    (a) Necessary Interest - Incurred to satisfy a financial need of the provider on a loan made for a purpose directly related to patient care. Necessary interest cannot include loans resulting in excess funds or investments.
    (b) Proper Interest - Must be necessary as described above, incurred at a rate not in excess of what a prudent borrower would have to pay in the money market at the time the loan was made, and incurred in connection with a loan directly related to patient care or safety.
17. Interim Encounter Rate - A rate intended to approximate the provider's actual or allowable costs of services furnished until such time as actual allowable costs are determined.
18. Medicaid - The Alabama Medicaid Agency.
19. Medicaid Reimbursement Principles - A combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and procedures and principles published by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated FQHCs.
20. Necessary Function - A function being performed by an employee which, if that employee were not performing it, another would have to be employed to do so, and which is directly related to providing FQHC services.
21. Pension Plans - A pension plan is a type of deferred compensation plan which is established and maintained by the employee primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement.
22. Proprietary Provider - Provider, whether a sole proprietorship, partnership, or corporation, organized and operated with the expectation of earning profit for the owners as distinguished from providers organized and operated on a nonprofit basis.

23. Provider - A person, organization, or facility who or which furnishes services to patients eligible for Medicaid benefits.
24. Prudent Buyer Concept - The principle of purchasing supplies and services at a cost which is as low as possible without sacrificing quality of goods or services received.
25. Reasonable Compensation - Compensation of officers and/or employees performing a necessary function in a facility in an amount which would ordinarily be paid for comparable services by a comparable facility.
26. Reasonable Costs - Necessary and ordinary cost related to patient care which a prudent and cost-conscious businessman would pay for a given item or service.
27. Related - The issue of whether the provider and another party are "related" will be determined under the HIM-15 rules as to classification as "related" parties. (See HIM-15.)
28. Secretary - "Secretary" means the Secretary of Health and Human Services or his delegate.
29. Sick Leave - A benefit granted by an employer to an employee to be absent from their job for a stipulated period of time without loss of pay.
30. State Plan - The State Plan published by the State of Alabama under Title XIX of the Social Security Act Medical Assistance Program.
31. Unallowable Costs - All costs incurred by a provider which are not allowable under the Medicaid Reimbursement Principles.
32. Vacation Costs - A vacation benefit is a right granted by an employer to an employee (a) to be absent from his job for a stipulated period of time without loss of pay or (b) to be paid an additional salary in lieu of taking the vacation.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.04. Reimbursement Methodology.

1. A Medicaid prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs) was enacted into law under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. As described in section 1902(aa) of the Social Security Act, FQHCs will be paid under a prospective payment system effective January 1, 2001. Prior to enactment of BIPA, FQHCs were reimbursed by an established encounter rate based on 100% of reasonable allowable cost for Medicaid covered services provided by the FQHC. With the implementation of BIPA, FQHC providers that provided Medicaid covered services for the period October 1, 2000, through December 31, 2000, will file a cost report and it will be settled. For the period January 1, 2001, through September 30, 2001, Alabama Medicaid Agency will pay FQHCs 100% of the average of their reasonable costs of providing Medicaid covered services during FY 1999 and FY 2000, adjusted to take into account any increase (or decrease), see paragraph (3) below, in the scope of services furnished during FY 2001 by the FQHC (calculating the payment amount on a per visit basis). Beginning in FY 2002, and for each fiscal year thereafter, each FQHC is entitled to the payment amount (on a per visit basis) to which the FQHC was entitled to in the pervious fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during that fiscal year.
2. Reimbursement for an enrolled out-of-state FQHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state FQHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

3. A new FQHC provider or a provider who constructs, leases, or purchases a facility, or has a Medicaid approved change in the scope of services, can request reimbursement based on an operating budget, subject to the ceiling established under this rule. After the actual cost report is received and desk reviewed for the budget period, an actual encounter rate will be determined. In this event, the FQHC may be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. This difference may be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference. After the initial year, payment shall be set using the MEI methods used for other FQHCs. An FQHC that has a change of ownership can retain the previous owner's encounter rate if desired.
4. Costs Reimbursed by Other Than FQHC Encounter Rate. Costs that are reimbursed by other Alabama Medicaid Agency programs will not also be reimbursed in the FQHC Program. Examples of such reimbursements include, but are not limited to:
   (a) Maternity Waiver - Primary Contractor
   (b) (Note: Costs for Maternity Waiver sub-contractors are not an allowable cost and will be shown only in the non-reimbursable section of the cost report.)
   (c) Prescription Drugs by enrolled pharmacy providers
   (d) In-patient and out-patient surgical service fee-for-service payments.

   In order to keep from paying for such services twice, the payments for the programs above will be deducted from the FQHC settlements.
5. Unrestricted grants, gifts, private donations or the income from such items, and income from endowments will not be deducted from operating costs in computing reimbursable cost. Public Health Service Grants are considered unrestricted grants. Grants, gifts, private donations, or the income from such items, or endowment income designated by a donor for paying specific operating costs must be deducted from the particular operating cost or group of costs.

Author: Keith Boswell, Reimbursement/QA

Statutory Authority: State Plan; Title XIX, Social Security Act Sec. 1902(a)(13), Balanced Budget Act of 1997, Sec. 4712(c), 42 C.F.R. Section 405.2401 - .2429, Section 702, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

History: Rule effective April 15, 1993. Amended October 1, 1993; March 15, 1994; July 10, 1998, January 13, 2000. Amended: Emergency Rule filed and effective March 20, 2001. Amended: Filed March 20, 2001; effective June 15, 2001. Amended: Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-56-.05. Medicaid Inflation Index.

1. The Medicaid Inflation Index will be used in lieu of budgeting to adjust certain actual allowable costs from one reporting period for the purpose of computing the encounter rate payable for a subsequent reporting period and for such other adjustments as may be specified in this Chapter.
2. The Medicaid Inflation Index shall be based upon the economic indicators as published in Health Care Costs by Data Resources, Inc. (DRI). The indicators shall be in the table of Individual Price and Wages Indexes, under Services, and identified as Medical Care, Services. The Medicaid Inflation Index for a rate period will be the DRI Index for the twelve month period ending on the calendar quarter for which the index has been published or made available at October 1st of each year.
3. The Medicaid Inflation Index will be established for the subsequent cost reporting period based upon the most current economic indicators available to Medicaid at desk review time and will not be adjusted again until the next rate setting period, regardless of any later release of revised or additional information relevant to the determination of the index.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R., Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.06. Encounters.

Encounters are face-to-face contacts between a patient and a health professional for the provision of medically necessary services. Contacts with more than one health professional and multiple contacts with the same health professional, that take place on the same day and at a single location, constitute a single encounter unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. This does not apply to dental service; however, dental services are limited to one dental encounter per date of service. Therefore, a patient can have one dental encounter and one other encounter on the same day. Services incident-to an encounter are inclusive.

Encounters are classified as either billable or non-billable. Billable encounters are visits for face-to-face contact between a patient and a health professional in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable encounters are forwarded to the Fiscal Agent for payment through the proper filing of claims forms. Non-billable encounters are visits for face-to-face contact between a patient and health professional for services other than those listed above (i.e., visits to social worker, LPN). Such services include, but are not limited to, administering injections only, blood pressure checked only, and TB skin testing. Non-billable encounters can not be forwarded to the Fiscal Agent for payment. The costs of the non-billable encounters will be included in the allowable costs; however, the non-billable encounter will not be counted as an encounter on the cost report.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.07. Overhead Costs.

1. Overhead costs are those costs not directly related to patient care. Overhead costs are those costs related to the FQHC's facility and administration and management of the FQHC.
2. Examples of Overhead Costs include, but are not limited to:
    - (a) Salaries and benefit costs of the administration staff (Owners compensation should be limited to reasonable cost - i.e., that which would be paid to an unrelated employee performing the same function).
    - (b) Accounting and Auditing
        1. Routine Bookkeeping
        2. Preparation of cost reports
        3. Auditing and related statements
    - (c) Nominal meeting expenses for Board Members
    - (d) Legal costs related to patient care
    - (e) Data Processing
        1. Owned
        2. Rented
        3. Outside purchased service
    - (f) Housekeeping
    - (g) Maintenance
    - (h) Security
    - (i) Supplies
    - (j) Malpractice Insurance
    - (k) General Insurance
    - (l) Telephone
    - (m) Utilities (power, gas, and water)
    - (n) Rent

(o) Maintenance and Repairs

(p) Depreciation

(q) Amortization

(r) Mortgage Interest

(s) Other Interest

(t) Medical Records

(u) Home Office Cost (if appropriate)

(v) Management fees not exceeding the cost of the provider of the services and not excluded under another section of this Chapter

(w) Other costs, if appropriate

3. Purchase Discounts and Allowances, and Refunds of Expenses. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense. Discounts, in general, are reductions granted for the settlement of debts. Allowances are deductions granted for damage, delay, shortage, imperfection or other cause, excluding discounts and returns. Refunds are amounts paid back or a credit allowed on account of an over-collection. Rebates represent refunds of a part of the cost of goods or services. A rebate is commonly based on the total amount purchased from a supplier and differs from a quantity discount in that it is based on the value of purchases, whereas quantity discounts are generally based on the quantity purchased.

   All discounts, allowances, and refunds of expenses are reductions in the cost of goods or service purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they were received.

   Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due.

   Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable cost is required.

   In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

   As with discounts, allowances and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party organizations paying on the basis of cost.

4. Advertising Costs. The allowability of advertising costs depends on whether they are reasonable, appropriate and helpful in developing, maintaining, and furnishing covered services to Medicaid beneficiaries. To be reimbursable, such costs must be common and accepted occurrences in the field of the center's activity.

   Advertising costs incurred in connection with the center's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. These costs will be limited to $100.00 per year for the main clinic and each satellite that operates as a full-time clinic (i.e., if a FQHC has a main clinic and four satellites, it will be limited to a total of $500.00 per year). Costs connected with fund-raising are not included in this category and are therefore nonallowable.

Costs of advertising for the purpose of recruiting medical and paramedical personnel for the center's salaried staff are allowable. Costs incurred in advertising for administrative or clerical personnel are allowable if the personnel would be involved in patient care activities or the development and maintenance of the facility.

Advertising costs incurred in connection with obtaining bids for construction or renovation of the center's facilities should be included in the capitalized cost of the asset.

5. Insurance Costs. The reasonable costs of insurance purchased from a commercial carrier and not from a limited purpose insurer are allowable if the type, extent, and cost of coverage are consistent with sound management practice. Where a center has purchased insurance without the customary deductible feature and, as a result, is charged a substantially higher premium, the amount of the insurance premium which exceeds the insurance premium with the customary deductible clause is not an allowable cost.

   Generally, the following types of insurance are recognized:

   (a) Property Damage and Destruction. This type of insurance covers losses due to the damage to, or destruction of, the facility's physical property. Coverage is available to insure against losses resulting from fire or lightning, windstorm, earthquake, sprinkler leakage, water damage, automobile damage, etc.

   (b) Liability. This insurance includes professional liability (malpractice, error in rendering treatment, etc.), worker's compensation, automobile liability, and general liability.

   (c) Consequential Loss or Indirect Loss. There are various indirect losses a center may incur in connection with property damage or other occurrences which interrupt the normal operation of the institution. The cost of business interruption or other similar insurance is allowable; however, the premium costs for "guaranteeing profits" is not allowable.

   (d) Theft Insurance. This generally includes fidelity bonds and burglary insurance.

6. Taxes. When a center is liable for the payment of certain taxes, such payments made in accordance with the levying enactment of the state and lower levels of government may be included in allowable costs. The program will pay its proportionate share of such allowable expenses.

   Center's are expected to obtain exemption from taxation whenever they can legally do so. When such exemptions are available but the center neglects to take advantage of them, incurred expenses for such taxes will not be recognized as allowable costs under the program.

   Tax expense should not include fines and penalties. In general, taxes which the center is required to pay are includable in allowable costs except for:

   (a) Federal income and excess profit taxes.

   (b) State or local income and excess profit taxes.

   (c) Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

   (d) Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives.

   (e) Taxes on any property which is not used in the rendition of covered services.

   Taxes which are allowable for inclusion in costs under the program generally are included in overhead costs of the center.

7. Membership Costs. Centers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary operating costs. Generally, costs of centers memberships in professional, technical, and business related organizations are allowable for purposes of program reimbursement. Generally, social and fraternal organizations concern themselves with activities unrelated to their members' professional or business activities and are, therefore, not allowable.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.08. Personnel Costs.

1. Orientation and On-The-Job Training. The costs of orientation and on-the-job training are recognized as normal operating costs and are allowable. Ordinarily, such training would be imparted within the center setting. If, however, the training requires outside instructions, costs of such training are allowable, if reasonable.
2. Fringe Benefits. Fringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death.
3. The costs of fringe benefits must be reasonable and related to patient care. Medicaid recognizes the following fringe benefits:
   - (a) Facility contributions to certain deferred compensation plans, if the plan does not favor top management.
   - (b) Facility contributions to certain pension plans, if the plan does not favor top management.
   - (c) Paid vacation or leave, paid holidays, paid sick leave, voting leave, court or jury duty leave, all of which generally are included in employee earnings.
   - (d) Cost of health and life insurance premiums paid or incurred by the facility if the benefits of the policy inure to the employee or his beneficiary, if the plan does not favor top management.
   - (e) Other items not enumerated above may represent fringe benefits.
   - (f) However, before any other item is treated as a fringe benefit, refer it to the Medicaid Agency for approval.
4. Sick Leave. The reasonable cost of sick leave taken by an employee of a center is recognized as a fringe benefit and included in allowable costs only when the facility makes payment for the sick leave. Payment in lieu of sick leave taken is not recognized by the program as payment for sick leave but is recognized as additional compensation. To be included in allowable costs, this payment in lieu of sick leave taken, along with other forms of compensation paid to an employee, must be reasonable.
5. Vacation Costs. A vacation benefit is a right granted by an employer to an employee (a) to be absent from his job for a stipulated period of time without loss of pay or (b) to be paid an additional salary in lieu of taking the vacation. Vacation costs must meet all of the following conditions to be included in allowable costs.
6. These costs must be included in the cost reporting period in which they are earned by the employee and must be computed from actual payroll records as related to each employee.
7. Where the center's vacation policy is consistent among all employees, the vacation must be taken or, if the employee elects to be paid in lieu of taking a vacation, the payment must be made within the period consistent with the vacation policy established by the center. Where the policy is not consistent among all employees, the vacation must be taken or payment in lieu of vacation must be made within two years after the close of the cost reporting period in which the vacation is accrued. If payment is not made within the required period of time or in those instances where the vacation benefits, accrued and included in allowable costs, are forfeited by the employee for cause, the current year cost report must be adjusted.
8. Amounts allowed for vacation benefits must be reasonable in themselves and, together with other compensation, result in reasonable compensation for services rendered.
9. Employer payroll taxes applicable to vacation, such as FICA, must not be accrued, but treated as a cost in the period when the vacation costs are paid.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.09. Travel Expense.

1. Travel expense incurred by a facility to send employees (except physicians, which is covered below) to attend a required educational workshop within the state which increases the quality of medical care and/or the operating efficiency of the facility is an allowable cost. Workshops on medical techniques, health applications, data processing, clinic accounting and cost finding, and other administrative activities are examples of the types of workshops for which travel expense will be recognized. Travel expense incurred by a facility to send physician employees to attend educational workshops for licensure requirements is an allowable cost if the workshop is held within the state. Any physician educational costs above the licensure requirements is an unallowable cost. Travel that is necessary and that is directly related to the operation of the clinic claiming reimbursement for the expense will be an allowable cost for reimbursement purposes pursuant to the following specific provisions.

   (a) Automobile

      1. Reimbursement will be based on a standard mileage rate and will be limited to mileage which is documented by log entries prepared in accordance with either of the attached sample logs. (See Schedules 9A and 9B found at end of chapter.) Reimbursement to employees for the use of their personal vehicles will be limited to the lessor of the actual reimbursement to the employee or the standard mileage rate per section (1)(a)3 of this rule.

         All log entries must be made at the time of travel, and log entries will be subject to verification during audit. Failure to timely and accurately account for travel mileage will result in a disallowance of this cost.

      2. Commuting mileage between the commuter's residence and the FQHC is not allowable mileage for reimbursement purposes. Non-patient care travel is also not allowable.

      3. The standard mileage rate is as follows: The IRS mileage rates in effect on January 1 of the calendar year in which the cost report is filed (January 1, 1991 for cost reports filed as of September 30, 1991). These rates will be applied on a per provider basis regardless of the number or type of vehicles used.

      4. No reimbursement will be made or considered for unusual or impractical vehicles, which include but are not limited to aircraft, motorcycles, farm equipment and other vehicles not necessary to the efficient operation of the center. Vehicles used as clinics to provide for the delivery of Health Services for the Homeless, under the direction of Public Health Grant 340, will not be reimbursed mileage; but, will be reimbursed for gas, oil, depreciation, interest, insurance, taxes, and repair and maintenance.

   (b) Other Travel

      1. Costs of travel to out-of-state conventions or association meetings will be limited to those reasonable costs incurred by a center for two trips during each fiscal year. If the center bears the expenses of two persons attending the same convention or association meeting, such attendance will be counted as two trips. Reimbursement will be considered only for bona fide employees of the center whose attendance will benefit the operation of the center. Expenses related to travel expenses of employee spouses will not be eligible for reimbursement unless the spouse is a bona fide employee of the facility and has a legitimate reason, related to patient care, for such attendance. Since only patient care related travel is allowable, evidence must be on file to verify that the travel was patient related. Such evidence may be: (a) seminar registration receipts, (b) continuing education certificates, or (c) similar documentation. If verification cannot be made, reimbursement will not be allowed. Out-of-state travel living expenses will be limited to $125.00 per day for the length of the functions attended. Per diem for the date of return will be limited to $50.00 because lodging is not required.

2. Travel expenses in or out-of-state will be limited to the ordinary and necessary costs of transportation, food, lodging, and required registration fees.
3. Whenever out-of-state travel could be accomplished at a lower cost by utilizing air travel, reimbursement will be limited to the costs which would have been incurred if such air travel had been utilized and the costs normally incident to such air travel (meals, lodging, etc.).
4. No travel expenses of a nonbusiness nature will be reimbursed.
5. Travel which requires an overnight stay must be documented by a travel voucher which includes the following:
   i. Date
   ii. Name of person
   iii. Destination
   iv. Business purpose
   v. Actual cost of meals and lodging (lodging must be supported by invoices, meal receipts must indicate number of meals served for any meal in excess of $10.00).
   vi. Air, rail and bus fares (supported by an invoice)

2. Travel associated with political activities or lobbying efforts is not allowable. This type of travel is not directly related to patient care.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.10. Property Costs.

1. General Principles Relating to Property Costs. Property Costs include, but are not limited to, depreciation, interest, lease and rental payments, insurance on buildings and contents, and property taxes. In addition to the limitations contained in this rule, all property costs will be subject to the "prudent buyer" concept with each case to be considered on its own merit. Also, depreciation, interest, rent, insurance, and taxes associated with space and equipment used for non-covered services or activities must be eliminated from allowable property costs.
2. Depreciation
   (a) Depreciation is that amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period or operation. The amount of depreciation is determined by using the straight line method.
   (b) The principles of reimbursement for facility costs provide that payment for services should include depreciation on all depreciable type assets that are used to provide covered services to beneficiaries. This includes assets that may have been fully (or partially) depreciated on the books for the facility but are in use at the time the facility enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on a revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity. An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be: (1) identifiable and recorded in the facility's accounting records; (b) based on the historical cost of the asset or fair market value at the time of donation or inheritance, in the case of donated or inherited assets; and (c) prorated over the estimated useful life of the asset using the straight line method of depreciation.

(c) Depreciable Assets. Assets that a facility has an economic interest in through ownership regardless of the manner in which they were acquired, are subject to depreciation. Generally, depreciation is allowable on the assets described below when required in the regular course of providing patient care. Assets which a facility is using under a regular lease arrangement would not be subject to depreciation by the facility.

(d) Buildings. Buildings include, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

(e) Building Equipment. Building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc. The general characteristics of this equipment are: (1) affixed to the building, and not subject to transfer; and (2) a fairly long life, but shorter than the life of the building to which affixed. Since the useful lives of such equipment are shorter than those of the buildings, the equipment may be separated from building cost and depreciated over this shorter useful life.

(f) Major Moveable Equipment. Major moveable equipment includes such items as accounting machines, beds, wheelchairs, desks, vehicles, X-ray machines, etc. The general characteristics of this equipment are: (1) a relatively fixed location in the building; (2) capable of being moved as distinguished from building equipment; (3) a unit cost sufficient to justify ledger control; (4) sufficient size and identity to make control feasible by means of identification tags; and (5) a minimum life of approximately three years.

(g) Minor Equipment. Minor equipment must be expensed as of the date of purchase. Minor equipment includes such items as waste baskets, syringes, catheters, mops, buckets, etc. The general characteristics of this equipment are: (1) in general, no fixed location and subject to use by various departments of the facility; (2) comparatively small in size and unit cost; (3) subject to inventory control; (4) fairly large quantity in use; and (5) generally, a useful life of approximately three years or less.

(h) Land (Non-depreciable). Land (non-depreciable) includes the land owned and used in facility operations. Included in the cost of land are the costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the facility, and other land expenditures of a non-depreciable nature.

(i) Land Improvements (Depreciable). Depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the facility).

(j) Lease Hold Improvements. Lease hold improvements include betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

(k) Accounting Records. The depreciation allowance, to be acceptable, must be adequately supported by the facility's accounting records. Appropriate recording of depreciation requires the identification of the depreciable assets in use, the assets' historical cost (or fair market value at the time of donation in case of donated assets), the method of depreciation, and the assets' accumulated depreciation.

(l) Useful Life of Depreciable Assets. The depreciable life of an asset is its expected useful life to the facility; not necessarily the inherent useful or physical life. The useful life is determined in light of the facilities experience and the general nature of the asset and other pertinent data. Some factors for consideration are: (1) normal wear and tear, (2) obsolescence due to normal economic and technological advances, (3) climatic and other local conditions, and (4) facility's policy for repairs and replacement. In projecting a useful life, facility's are to follow the useful life guidelines published by the American Hospital Association (See Schedule at end of Chapter). The agency may allow lives different from these guidelines, if the provider requests consideration in writing. However, the deviation must be based on convincing reasons supported by adequate

documentation, generally describing the realization of some unexpected event. Factors such as an expected earlier sale, retirement or demolition of an asset may not enter into a determination of the expected useful life of an asset.

(m) Acquisitions. If a depreciable asset has at the time of its acquisition an estimated useful life of at least two (2) years and a historical cost of at least $300, or, if it is acquired in quantity and the cost of the quantity is at least $500, its cost must be capitalized, and written off ratably over the estimated useful life of the asset. If a depreciable asset has a historical cost of less than $300 or, if it is acquired in quantity and the cost of the quantity is less than $500 or if the asset has a useful life less than two (2) years, its cost is allowable in the year it is acquired. The facility may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the above criteria be exceeded.

(n) Determining Depreciation in Year of Acquisition and Disposal. The amount of depreciation recorded during the year of acquisition and year of disposal varies among centers. The following methods are acceptable for computing first and last year depreciation amounts. Any other method for computing first and last year depreciation must be approved by the Medicaid Agency. Whatever method is adopted, it must be applied to all assets subsequently acquired.

1. Time Lag Alternatives. These result in delayed recording of depreciation after the actual date of acquisition. However, they provide the convenience of updating detailed, supportive accounting records at the end of certain time intervals.

   i. Up to Six Months Lag. Assets acquired during the first six months of the reporting year are subject to depreciation beginning with the first day of the seventh month of the reporting year. Assets acquired during the second six months of the reporting year are subject to depreciation beginning with the first day of the subsequent reporting year. Depreciation on disposal is based on the portion of the year in which the asset is disposed. If the asset is disposed of in the first half of the reporting year, one-half year's depreciation is taken. If the asset is disposed of in the second half of the year, a full year's depreciation is taken.

   ii. Up to One Year Time Lag. Assets acquired during the reporting year become effective for depreciation on the first day of the subsequent reporting year. In the year of disposal a full year's depreciation is taken.

2. Half Year Depreciation. One-half year depreciation is taken in the year of acquisition regardless of acquisition date and one-half year depreciation is taken on disposition regardless of disposition date.

3. Actual Time Depreciation. Depreciation for the first reporting period is based on the length of time from the date of acquisition to the end of the reporting year. Depreciation on disposal is based on the length of time from the beginning of the reporting year in which the asset was disposed to the date of disposal.

(o) Disposal of Assets. Depreciable assets may be disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, fire or other casualty. In such cases, depreciation can no longer be taken on the asset, and gain or loss on the disposition must be computed. Where an asset has been retired from active service, but is being held for standby or emergency services, depreciation may continue to be taken on such assets. However, where asset has been permanently retired, or there is little or no likelihood that it can be effectively used in the future, no further depreciation can be taken on the asset. In such case, gain or loss on the retirement must be computed.

3. Interest

(a) Necessary and reasonable interest expense on both current and capital indebtedness is an allowable cost. Interest is the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user. Interest on current indebtedness is the cost incurred

for funds borrowed for a relatively short term, usually for one (1) year or less. Current borrowing is usually for purposes such as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as the acquisition of facilities, equipment, and capital improvements. Generally, loans for capital purposes are long-term loans. Interest is usually expressed as a percentage of the principal. Sometimes, it is identified as a separate item of cost in a loan agreement. Interest may be included in "finance charges" imposed by some lending institutions or it may be a prepaid cost or "discount" in transactions with those lenders who collect the full interest charges when funds are borrowed. Reasonable finance charges and service charges together with interest on indebtedness are includable in allowable cost. To be allowable, interest must be: (1) supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required; (2) identifiable in the facilities accounting records; (3) related to the reporting period in which the costs are incurred; and (4) necessary and proper for the operation, maintenance, or acquisition of the center's facilities. To support the existence of a loan, the facility should have available a signed copy of the loan contract which should contain the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc. Where the lender does not customarily furnish a copy of the loan contract, correspondence from the lender stating the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc., will be acceptable. Various methods of identifying and accounting for interest costs are used. These include periodic cash payments of interest with or without repayment of all or part of the loan; prepayment of interest when the liability is incurred with charges to interest expense recorded in relation to the accounting period; and accrual of interest with no cash payment with a corresponding record of the unpaid liability reflected in the accounting records. The method actually used depends on the type of loan and the terms of the loan agreement. Where interest expense has been determined to be allowable and the interest expense records are maintained physically away from the facility premises such as in a county treasurer's office, such records will be deemed to be those of the facility. This would be applicable where bond issues have been specifically designated for the construction or acquisition of the centers facilities and the financial records relative to the bond issue are maintained by some governmental body other than the facility.

(b) Necessary Interest. Necessary means that the interest be incurred on a loan made to satisfy a financial need of the facility and for a purpose reasonably related to patient care. For example, where funds are borrowed for purposes of investing in other than the facility's operations, interest expense is not allowable, such a loan is not considered "necessary." Likewise, when borrowed funds create excess working capital, interest expense on such borrowed funds is not an allowable cost. Necessary also requires that the interest be reduced by investment income. There is an exception to this general rule where the investment income is from grants and gifts, whether restricted or unrestricted, and which are not commingled with other funds. "Not commingled" means that the funds are kept physically apart in a separate bank account and not simply recorded separately in the facility's accounting records.

(c) Proper Interest. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arms-length transaction in the money market when the loan was made. In addition, the interest must be paid to a lender not related to the facility through common ownership or control.

(d) Mortgage Interest. A mortgage is a lien on assets given by a borrower to a lender as security for borrowed funds for which payment will be made over an extended period of time. Mortgage interest refers to the interest expense incurred by the borrower on a loan which is secured by a mortgage. Usually such loans are long-term loans for the acquisition of land, buildings, equipment, or other fixed assets. Mortgage loans are customarily liquidated by means of periodic payments, usually monthly, over the term of the mortgage. The periodic payments usually cover both interest and principal. That

portion which is for the payment of interest for the period is allowable as a cost of the reporting period to which it is applicable. In addition to interest expense, other expenses are incurred in connection with mortgage transactions. These may include attorney's fees, recording costs, transfer taxes and service charges which include finder's fees and placement fees. These costs, to the extent that they are reasonable, should be amortized over the life of the mortgage in the same manner as bond expenses. The portion applicable to the reporting year is an allowable cost.

(e) Interest During Period of Construction. Frequently, centers may borrow funds to construct facilities or to enlarge existing facilities. Usually, construction of facilities will extend over a long period of time, during which interest costs on the loan are incurred. Interest costs incurred during the period of construction must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care. If the construction is an addition to an existing facility, interest incurred during the construction period on funds borrowed to construct the addition must be capitalized as a cost of the addition. After the construction period, interest on the loan is allowable as an operating cost.

(f) Interest on Notes. A note is the contractual evidence given by a borrower to a lender that funds have been borrowed and which states the terms for repayment. Interest on notes is allowable as a cost in accordance with the terms of the note. Frequently, a note is issued as an instrument evidencing a loan which may have a term running several years. The interest on such a loan is incurred over the period of the loan. Under the accrual method of accounting, the interest cost incurred in each reporting period is an allowable cost in the applicable reporting period. If, under the terms of the loan, the interest is deducted when the loan is made (discounted), the interest deducted should be recorded as prepaid interest. A proportionate part of the prepaid interest is allowable as cost in the periods over which the loan extends.

4. Sale and Lease back and Lease-Purchase Agreements.

(a) Sale and Lease back Agreements - Rental Charges. Where a facility enters into a sale and lease back agreement with a non-related purchaser involving plant facilities or equipment, the incurred rental specified in the agreement is includable in allowable cost if the following conditions are met:

1. The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition and value of the facilities or equipment rented and other provisions of the rental agreements;
2. Adequate alternate facilities or equipment which would serve the purpose are not or were not available at lower cost; and
3. The leasing was based on economic and technical considerations.
4. If all these conditions were not met, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs had he retained legal title to the facilities or equipment, such as interest or mortgage, taxes, depreciation, insurance and maintenance costs.

(b) Lease Purchase Agreement - Rental Charges.

1. Definition of Virtual Purchase. Some lease agreements are essentially the same as installment purchases of facilities or equipment. The existence of the following conditions will generally establish that a lease is a virtual purchase:

i. The rental charge exceeds rental charges of comparable facilities or equipment in the area;

ii. The term of the lease is less than the useful life of the facilities or equipment; and

iii. The center has the option to renew the lease at a significantly reduced rental, or the center has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the center is permitted.

2. Treatment of Rental Charges. If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased. If the asset is returned to the owner, instead of being purchased, the deferred charge may be expensed in the year the asset is returned. Where the term of the lease is extended for an additional period of time, at a reduced lease cost, and the option to purchase still exists, the deferred charge may be expensed to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership. On the other hand, if the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be expensed to the extent of increasing the reduced rental to a fair rental value.

5. Allowance for Depreciation on Facilities Leased for a Nominal Amount.

(a) Some centers might lease their facilities from municipalities at a nominal rental (usually for $1.00 per year) and the lease generally covers the useful life of the facility. Under most lease arrangements the tenant (lessee) maintains the property and pays the cost of any improvement or addition to the facility. When such improvement or addition is made the lessee may properly amortize its cost. The amortization allowance is includable in allowable cost. At the end of the lease, improvements and additions made by the lessee become the property of the lessor. However, in some instances the lease agreement provides that title to any additions or improvements is to revert to the owner in the first year they are used. In such cases, the cost of any addition or improvement would be similarly amortized and the amortization allowance would also be includable in allowable cost. It is the general practice of the center to include its charges (and cost) an amount to cover depreciation on the leased facilities as distinguished from capital improvements made by the lessee. In recognition of this practice, most third parties that reimburse centers on the basis of cost allowed depreciation (but not interest) on facilities that have been leased for a nominal rental. In view of this and since this type lease arrangement in such cases generally contemplates the occupancy by the lessee for the period of the useful life of the facility, depreciation on the leased facility may be included in allowable cost under the conditions described below.

(b) Analysis of Lease Arrangement. Each case must be decided on its own merit for depreciation to be allowed. The lease must contemplate that the lessee will make any necessary improvements and will properly maintain the facility. The lease may and frequently does cover the useful life of the asset; if not, however, as in the case of the year to year lease, such lease should be examined closely to determine whether the renewal and other provisions of the lease contemplate that the center will use the facility to the extent of its useful life. Where the intent and provisions of the year to year lease permit the center to have the benefit of the useful life of the facility, such lease should be treated, for depreciation purposes, in the same manner as a long-term lease that covers the useful life of the asset. The actions of the lessee and lessor in such cases should indicate that the intent of both parties is to continue the lease arrangements for the useful life of the asset. Of course, other facts should be considered together with the past actions of the lessee and lessor in order to determine whether or not the asset will and can be used by the lessee for the asset's full useful life. The lease should have no restrictions on the free use of the facility by the lessee. In addition, the lease should not provide for any indirect benefits to the lessor or to those connected with the lessor. For

example, if the lease requires that the lessee furnish free clinic services to the employees of the lessor, then depreciation should not be allowed. In such cases, the cost of the services furnished to the lessor's employees would be appropriately included when determining allowable costs.

6. Equipment Rental. Reasonable costs of such rental equipment as is normally and traditionally rented by health care institutions and which is rented from a non-related organization, are allowable provided the arrangement does not constitute a lease-purchase agreement. All items leased under a lease-purchase agreement must be capitalized and depreciated over the useful life of the asset.
7. Insurance on Building and Contents. The reasonable costs of insurance on buildings and their contents used in rendition of covered services purchased from a commercial carrier and not from a limited purpose insurer (Ref. HIM-15, Section 2162(2)) will be considered as allowable costs.
8. Property Taxes. Ad valorem and personal property taxes on property used in the rendition of covered services are allowable under this section. Fines, penalties or interest related to those taxes are not allowable.
9. Life and Rental Insurance. Premium payments for life insurance required by a lender or otherwise required pursuant to a financing arrangement will not be an allowable cost. Loss of rental insurance will also be considered an unallowable cost.
10. Donation of the use of space. An FQHC may receive a donation of the use of space by another organization. In such case, the FQHC may NOT impute a cost for the value of the use of space and include the imputed cost in allowable costs. The FQHC can include in the allowable costs of the FQHC, items such as costs of janitorial services, maintenance, repairs, etc., if used full time by the FQHC for patient related care and paid for by the FQHC.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.11. Costs to Related Parties.

1. Allowable costs incurred by a provider for services or goods provided by Related Parties will not exceed the net cost of the services or goods to that Related Party, and that cost cannot exceed the fair market value of the items or services involved.
2. Under no circumstances will rent paid to a Related Party be includable in allowable costs. In such cases, lessor's costs may be included in allowable costs provided that such costs do not exceed the fair market value of the leased assets.
3. The provisions of HIM-15 shall be applicable in determining whether a Related Party relationship exists.

Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.12. Chain Operations.

A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care.

The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicaid program is that of a related organization to participating facilities. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services management direction and control, and other services. To the extent the home office furnishes services related to patient care to a facility, the reasonable costs of such services are includable in the facility's cost report and are reimbursable as part of the facility's costs. Where the home office of the chain provides no services related to patient care, no home office cost may be recognized in determining the allowable costs of the facilities in the chain.

Very often the home office of a chain organization charges the facility in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, and such fees must be deleted from the facility's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the facility.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.13. Unallowable Expenses.

1. General
   - (a) All payments to providers for services rendered must be based on the reasonable cost of such services covered by the Alabama State Plan. It is the intent of the program that providers will be reimbursed the reasonable costs which must be incurred in providing quality patient care. Implicit in the intent that reasonable costs be paid are the expectations that the provider seeks to minimize costs and that costs do not exceed what a prudent and cost-conscious buyer pays for a given item of service or product. If costs are determined to exceed the level that prudent buyers incur in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not allowable.
   - (b) Costs related to patient care include necessary and proper costs involved in developing and maintaining the efficient operation of patient care facilities. Necessary and proper costs related to patient care are those which are usual and accepted expenses of similar providers.
2. Overhead costs which will not be allowed are listed below. This listing is not intended to be all inclusive. Other overhead costs which violate the prudent buyer concept or are not related to patient care will not be reimbursed by the Alabama Medicaid Agency.
   - (a) Management Fees. Management firms, individuals and consultants which duplicate services already provided, or in a clinic in which a full-time administrator is employed. Excluded from this rule are those management contracts required incident to a bond issue for a valid business purpose.
   - (b) Director's Fees
   - (c) Compensation to owners and other personnel not performing necessary functions
   - (d) Salaries which are paid to personnel performing overlapping or duplicate functions
   - (e) Legal Fees and Expenses
     1. Retainers
     2. Relating to informal conferences and fair hearings
     3. Relating to issuance and sale of capital stock and other securities
     4. Relating to creation of corporations or partnerships
     5. Relating to business reorganization
     6. Services for benefits of stockholders
     7. Acquisition of clinics or other business enterprises
     8. Relating to sale of clinics and other enterprises
     9. In connection with criminal actions resulting in a finding of guilt or equivalent action or plea
     10. Other legal services not related to patient care

(f) Outside Accounting and Audit Fees and Expenses

1. Personal tax returns
2. Retainers
3. Relating to informal conferences and fair hearings
4. Relating to issuance and sale of capital stock and other securities
5. Relating to creation of corporations or partnerships
6. Relating to business reorganization
7. Services for the benefits of stockholders
8. Acquisition for clinics or other business enterprises
9. Relating to sale of clinics and other enterprises
10. In connection with participation in criminal actions resulting in guilt or equivalent action or plea
11. Other accounting services not related to patient care

(g) Taxes

1. Personal income
2. Property not related to patient care
3. Corporate income tax
4. Vehicle tag & tax

(h) Dues

1. Club
2. Civic
3. Social
4. Professional organization dues for individuals
5. Non-patient care related organization

(i) Insurance

1. Life
2. Personal property not used in patient care
3. On real estate not used in providing patient care
4. Group life and health insurance premiums which favor owners of a clinic or are for personnel not bona fide employees of the clinic

(j) Special assessments from Primary Health Care Association

(k) Bad debts and associated collection expenses

(l) Employees relocation expenses

(m) Penalties

1. Late Tax
2. Late payment charges. (None: If a clinic can fully document that a late payment charge is directly due to late Medicaid payments, the amount of the late payment charge will be an allowable cost.)
3. Bank overdraft
4. Fines

(n) Certain Real Estate Expenses

1. Appraisals obtained in connection with the sale or lease of a clinic (unless required by Medicaid)
2. Costs associated with real estate not related to patient care

(o) Interest Expense

1. Interest associated with real estate in excess of clinic needs or real estate not related to patient care.
2. Interest expenses applicable to penalties
3. Construction Interest (must be capitalized)
4. Interest paid to a related party
5. Interest on personal property not related to patient care.
6. Interest on loans not associated with patient care

(p) Licenses

1. Consultants
2. Professional personnel

(q) Donations and Contributions

(r) Accreditation Surveys

(s) Telephone Services

1. Mobile telephones, beepers, telephone call relays, automated dialing services
2. Long distance telephone calls of a personal nature

(t) Any costs associated with corporate stock records maintenance

(u) Any expenses associated with political activities or lobbying efforts are not allowable

3. Prior Period Costs and Accounts Payable

(a) The Medicaid reimbursement rate is calculated to provide adequate funds to pay business expenses in a timely manner. Costs incurred in prior periods but not paid must be accrued and reported in that period during which the costs were incurred. Payment of prior period cost in the current year is not an allowable cost. Exceptions will be allowed, based on reasonableness, for small invoices which, in total, do not exceed $500.00 per fiscal period. These invoices must be as a result of no fault of the provider. Any pattern of abuse will cause the costs in question to be automatically disallowed by the Agency.

(b) Short-term liabilities must be paid within ninety (90) days from the date of invoice; otherwise, the expense will not be allowed unless the provider can establish to the satisfaction of Medicaid that the payment was not made during the 90 days for a valid business reason.

(c) Actual payment must be made by cash or negotiable instrument. For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and must be payable to order of or to bearer. All voided instruments, whether voided in fact or by devise, are considered void from inception.

(d) A provider who files for and is awarded protection under Chapter 11 of the Federal Bankruptcy Code may be given consideration in a current year cost report for actual payment of prior period allowable costs which have been disallowed in prior period cost reports due to failure to make actual payment of the cost claimed. In order for payment of these prior year allowable costs to be considered under a current year cost report, they must have been paid pursuant to a court approved plan for reorganization under Chapter 11 of the Federal Bankruptcy Code. The allowable costs will not include any interest or penalty incurred for failure to make payment in prior year. The Agency will not reimburse

interest expense generated from loans incurred to pay any such allowable prior period costs. Any such (untrended) allowable cost shall be added to the encounter rate after the normal rate setting process. It will be subject to the 80th percentile ceiling, thus the providers cost must be below the ceiling rate for any possible reimbursement of these prior period costs to occur.

4. Bad Debts. Bad debts resulting from beneficiaries' failure to pay are to be treated as noncovered costs. Hence, such bad debts cannot be included in a computation of the average cost per encounter.
5. Research Costs
   (a) Costs, incurred for research purposes, over and above usual patient care, are not includable as allowable costs.
   (b) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and clinic research needs
6. Luxury Items or Services
   (a) Where clinic operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.
   (b) Luxury items or services are those that are substantially in excess of or more expensive than the usual items or services rendered within a clinic's operation to the majority of patients.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993. Effective date of this amendment October 1, 1993.

Rule No. 560-X-56-.14. Accounting Records.

1. The provider must submit adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be presented on the accrual basis of accounting. This basis requires that revenue must be allocated to the accounting period in which it is earned and expenses must be charged to the period in which they are incurred, regardless of when cash is received or disbursed.
2. Cost and statistical information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for supplies, services, or assets. This includes all ledgers, books, records, and original evidence of costs which pertain to the costs reported. Financial and statistical records should be maintained in a consistent manner from one period to another; however, the regard for consistency should not preclude a desirable change in accounting procedures provided that full disclosure of significant changes is made.
3. The following records and documentation must be kept by the provider and must be available for audit inspection by Medicaid:
   (a) General Ledger
   (b) Disbursements Journal
   (c) Cash Receipts Journal
   (d) Payroll Journal
   (e) Working Trial Balance and Adjusting Entries
   (f) Patient Records
   (g) Purchases Journal
   (h) Time Sheets

4. All information contained in the provider's General Ledger must be capable of audit verification. Disbursements must be supported by invoices which detail the quantity and price of goods and services purchased, together with evidence that such goods and/or services were received. Disbursements made without proper documentation will not be allowable for Medicaid reimbursement purposes. This documentation should be filed in chronological order, either alphabetically or in some other reasonable manner capable of being audited. Payroll journals must be supported by time cards or other documentation, such as time sheets, signed by the employee and verified by his/her department head. (Time sheets for physicians can be signed for the physician by the clinic manager.) Each time card or other documentation must also indicate the hours worked by the employee, the rate of pay for the services rendered by the employee, and must be identified by the cost center, to which the expense should be charged.
5. Subsidiary records which must be kept by the provider and be readily available for audit and inspection include, but are not limited to:
   - (a) Accounts Receivable ledger sheets or cards which agree with the General Ledger control account (to include fiscal year end aging schedules)
   - (b) Accounts Payable Ledger sheets or cards which agree with the General Ledger control account (to include fiscal year end aging schedules)
   - (c) Notes Receivable
   - (d) Notes Payable
   - (e) Long-Term Debt evidenced by amortization schedules and copies of the original debt transaction
   - (f) Insurance policies together with invoices covering the fiscal year reported
   - (g) Depreciation Schedules showing the cost of the facility and equipment
   - (h) Payroll Tax Returns
   - (i) Income Tax Returns
   - (j) Bank Statements, cancelled checks, deposit slips, voided checks, and bank reconciliations
   - (k) A signed copy of the current lease
   - (l) Automobile travel logs
6. Petty Cash Funds shall be maintained under the Imprest System. The disbursement of these funds shall be substantiated by an invoice and/or voucher detailing the date of disbursement, expense category, and name of person disbursing the funds.
7. All documents, work papers, and schedules prepared by or on behalf of the provider which substantiate data in the cost reports must be made available to Medicaid auditors and investigators upon request.
8. The provider will provide adequate desk space and privacy to Medicaid auditors and investigators during the progress of audits. The provider's personnel or personnel representing an outside independent accountant may be present at a Medicaid audit and be allowed access to the Medicaid auditors and workpapers only at the invitation and discretion of the Medicaid auditors during the course of their work at the provider's establishment.
9. In the event a Medicaid auditor or investigator is denied access to a provider's records, the provider will be advised of the contract provisions governing inspection and review of these records by authorized representatives. The provider will be advised that if access to records is not granted, the provider will be given ten (10) calendar days in which to furnish the records to Medicaid at its Montgomery offices. If a provider fails to comply within the ten (10) day period, Medicaid will reduce all subsequent reimbursement payments by the costs it has been unable to substantiate.

10. If the provider fails to keep the minimum financial records required to properly substantiate reported costs, the provider will be subject to termination from the Medicaid program.
11. All books and records required to be kept and made available to Medicaid personnel by a provider will be made available at the facility unless this requirement is specifically waived in writing, in advance by Medicaid.
12. If a provider who has been given three (3) full working days notice of an audit fails to make the required records, including any not maintained at the facility, available at that facility, the Medicaid auditor(s) will return to the Medicaid Agency, and the provider will be given ten (10) calendar days to present all of the accounting records at the Medicaid office. Should the provider fail to present all of the accounting records at the Medicaid office during the allotted time period, Medicaid will consider all payments made to the provider during the time period covered by the records sought to be audited to be overpayments and may proceed to recover those overpayments from the provider.
13. If Medicaid is required to go out of state for an audit, the organization being audited will bear all expenses and costs related to the audit, including, but not limited to, travel and reasonable living expenses, and those costs will not be allowable on any subsequent cost report.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.15. Cost Reports.

1. Extensions. Each provider is required to file a complete uniform cost report for each fiscal year ending September 30th. A report of actual statistics and costs incurred during the entire preceding year is required. The cost report must actually be received by Medicaid on or before December 15th. Should December 15th fall on a state holiday or weekend, the cost report will be due the next following working day. Cost reports shall be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by the FQHC. Extensions may be granted only upon written approval by Medicaid for good cause shown. An extension request must be in writing, contain the reasons for the extension, and must be made prior to the cost report due date. Only one extension, for a maximum of thirty (30) days, per cost reporting year will be granted by the Agency.
2. Penalties. If a complete cost report is not filed by the due date, or an extension is not requested or granted, the provider shall be charged a penalty of one hundred dollars ($100.00) per day for each calendar day after the due date; this penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting documentation. Once a cost report is late, Medicaid shall suspend payments to the provider until the cost report is received. A cost report that is over ninety (90) days late may result in suspension of the provider from the Medicaid program. Further, the entire amount paid to the provider during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The provider will have thirty (30) days to either refund the overpayment or file the delinquent cost report after which time Medicaid may institute a suit or other action to collect this overpayment amount or the delinquent cost report.
3. Each cost report will be signed by the administrator or by an officer of the FQHC. The signature must be preceded by the following certification: I HEREBY CERTIFY that I have examined the accompanying worksheets prepared by _____ for the reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief it is a true, correct and complete statement prepared from the books and records of the FQHC in accordance with applicable instructions, except as noted.

_____

Signature (Officer or Administrator) Title Date

4. Any cost report received by Medicaid without the required original signature and/or without the required certification will be deemed incomplete and returned to the provider.
5. Cost reports should be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by providers. Cost reports will be deemed immutable with respect to the reimbursement for which the provider is entitled for the next succeeding fiscal year, one year from the date of its receipt by Medicaid, or its due date, whichever is later. Providers will have this one year period within which to resubmit their cost reports for the purpose of correcting any material errors or omissions of fact. This one year limitation does not apply to adjustments in cost reports that are initiated by Medicaid. Medicaid retains the right to make adjustments in cost reports at any time a material error or omission of fact is discovered.
6. Providers who terminate their participation in the Medicaid program, by whatever means, must provide a written notice to the Agency thirty (30) days in advance of such action. Failure to provide this written notice shall result in a one hundred dollar ($100.00) per day penalty being assessed for each day short of the 30 day advance notice period (up to a maximum of $3,000.00). Terminating providers must file a final cost report within seventy-five (75) days of terminating their participation in the program. Final payment will not be made by the Medicaid Agency until this report is received. Failure to file this final cost report will result in Medicaid deeming all payments covered by the cost report period as overpayments until the report is received. Additionally, a penalty of one hundred dollars ($100.00) will be assessed for each calendar day that the cost report is late.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.16. Audit Adjustment Procedures.

1. Audit adjustments will be paid or collected by a combination of (1) changing the encounter rate of the facility and (2) a lump sum settlement for the amount under/over paid for the period prior to the effective date of the encounter rate change.
2. Under/Overpayment situations arising from the audit of a terminating cost report will be paid or recouped by a lump sum settlement.
3. All adjustments will be subject to the limitations set out in this Chapter and subject to the appropriate ceilings.
4. Collection procedures will be applied only after the facility has been given thirty (30) days in which to disagree with any of the disallowances contained in the report of audit.
5. A final audit computation sheet will be forwarded to each facility with the report of audit. An adjusted encounter rate will be stated in the report of audit and will be computed based on the audit adjustments. This new encounter rate will be effective on the first day of a month, allowing for the thirty (30) day notification period and a reasonable amount of time for processing the report of audit. The effective date of the rate change will be shown on the final audit computation worksheet. The remaining portion of the audit settlement will be collected or paid in a lump sum amount. This lump sum amount for the months prior to the effective date (underpayment or overpayment period) of the rate change is computed by applying the adjustment per encounter to the total paid Medicaid encounters in the overpayment/underpayment period.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.17. Appeals.

1. Facility administrators who disagree with the findings of the Medicaid desk audits or field audits may request, in writing, an informal conference at which they may present their positions. Such written requests must be received by Medicaid within thirty (30) days of the date on which Medicaid mails the audit report, or new encounter rate, as the case may be, to the provider.
2. Administrators who believe that the results of the informal conference are adverse to their facility may ask, in writing, for a Fair Hearing, which will be conducted in accordance with Medicaid Regulations. Such written requests must be received by Medicaid within fifteen (15) days of the date on which Medicaid mails to the provider its determination on the issues presented at the informal conference.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.18. Negligence and Fraud Penalties.

1. Whenever an overpayment of Medicaid reimbursement received by a provider from Medicaid results from the negligent or intentional disregard of Medicaid Reimbursement Principles by the provider or its representatives (but without intent to defraud), there will be deducted from any reimbursement thereafter due the provider a penalty equal to 5% of such overpayment.
2. If any part of such an overpayment by Medicaid to the provider is due to fraud on the part of the provider or any of its representatives, there will be deducted from any subsequent reimbursement due the provider on proof of fraud, a penalty equal to 50% of the overpayment.
3. The penalties imposed under Rules No. 560-X-56-.18(1) and (2) of this Code shall be in addition to and shall in no way affect Medicaid's right to also recover the entire amount of the overpayment caused by the provider's or its representative's negligence or intentional disregard of the Medicaid Reimbursement Principles or fraud.
4. Whenever the cost of a good or service has been previously disallowed as the result of a desk audit of a provider's cost report and/or a field audit by Medicaid and such cost has not been reinstated by voluntary action of Medicaid as the result of an administrative hearing, or by a court order, such costs shall not thereafter be included as an allowable cost on a Medicaid cost report. The inclusion by the provider or its representative of such a cost on a subsequent cost report, unless the provider is actively pursuing an administrative or judicial review of such disallowance, will be considered as negligent and/or intentional disregard of the Medicaid Reimbursement Principles and subject to the 5% penalty imposed by Rule No. 560-X-56-.18(1) of this Code based upon the amount of overpayment which has or which would have resulted from the inclusion of such cost had its inclusion not been detected. Such inclusion shall also be subject to the provisions of Rule No. 560-X-56-.19 relating to intentional or negligent disregard of the Medicaid Reimbursement Principles.
5. For purposes of the preceding paragraph, a provider shall be considered as having included a previously disallowed cost on a subsequent year's cost report if the cost included is attributable to the same type good or service under substantially the same circumstances as that which resulted in the previous disallowance. Examples of such prohibited inclusions include, but are not limited to:
   - (a) Inclusion of the portion of rental payment previously disallowed as being between related parties.
   - (b) Inclusion of an amount of compensation which has previously been disallowed as unreasonable during a prior period.
   - (c) Inclusion of a cost not related to patient care which has previously been disallowed.
   - (d) Improper classification or allocation of costs to cost centers.
6. Rule No. 560-X-56-.18(4) shall NOT be interpreted as indicating that a provider's or his representative's initial entry of a cost item on a cost report will not be treated as a negligent or intentional disregard of the Medicaid Reimbursement Principles.
7. Any provider who knowingly files or allows to be filed a cost report which has been prepared by a person who has been suspended as a Cost Report Preparer during his period of suspension, shall be

subject to termination of its contract, and, in addition, subsequent reimbursement otherwise due the provider shall be reduced by $3,000.00, as though the cost report had not been received by Medicaid during the first thirty (30) day period following the due date for filing such report. (See Rule 560-X-56-.15.)

8. Providers and their representatives who are uncertain as to whether the inclusion of a cost in a cost report is in violation of the Medicaid Reimbursement Principles should footnote or otherwise call attention to the entry in question and specifically disclose the dollar amount and the portion of the cost report entry as to which they are in doubt.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Rule No. 560-X-56-.19. Cost Report Preparers.

1. Cost Report Preparers. "Cost Report Preparer" includes any person (including a partnership or corporation) who, in return for compensation, prepares or employs another to prepare all or a substantial portion of a Medicaid cost report. A Cost Report Preparer can include both the actual preparer of the report as well as his or her employer. Where more than one person aids in filling out a Medicaid cost report, the one who has primary responsibility for the preparation of the report will usually be a preparer, while those involved only with individual portions of the report will usually not be preparers. Any person who supplies enough information and advice so that the actual completion of the return is a mere mechanical or clerical matter is a Cost Report Preparer even though the person doesn't actually place or review the placement of the information on the cost report.
2. Refusal of Cost Reports. Medicaid will refuse to accept cost reports prepared by a Cost Report Preparer who:
   - (a) Has shown a pattern of negligent disregard of the principles established by or incorporated by reference into this Code;
   - (b) Prepares a cost report evidencing an intentional disregard of the Medicaid Reimbursement Principles;
   - (c) Has given false or misleading information, or participated in giving false or misleading information to any Medicaid employee, the Alabama Medicaid Agency, or to any hearing officer authorized to conduct hearings with regard to Medicaid reimbursement issues, knowing such information to be false or misleading. "Information" includes facts or other information contained in testimony, Medicaid Cost Reports, financial statements, affidavits, declarations, or any other documents or statements, written or oral.
   - (d) Medicaid will treat any cost report prepared by a Cost Report Preparer who has been determined to be ineligible to prepare Medicaid cost reports as incomplete and shall promptly return such Cost Report to the provider on whose behalf the report has been prepared. The receipt by Medicaid of such cost reports shall not satisfy, suspend, or stay the requirements of this Chapter relating to the timely filing of Medicaid Cost Reports.
3. Determination of Eligibility.
   - (a) Upon receipt by any Medicaid employee of information indicating that a Cost Report Preparer may have engaged in conduct which could result in the refusal by Medicaid to accept cost reports prepared by such preparer under Rule No. 560-X-56-.19(2) of this Section, such information shall be promptly reported to Medicaid's Director of Provider Audit who shall insure that an informal inquiry is made regarding the reliability of such information. Medicaid legal counsel and/or appropriate representatives of the Attorney General's office shall be consulted, as deemed appropriate.

(b) Informal Inquiry.

1. If the Medicaid Director of Provider Audit, based upon such informal inquiry, determines that there is substantial evidence that the preparer has engaged in conduct specified in Rule No. 560-X-56-.18, he will give written notice to the preparer which will offer the preparer the opportunity to refute such information or allegations. If the preparer fails to provide the Director of Provider Audit with information which results in a determination by the Director that the evidence of misconduct is insufficient to justify suspension, the Director will, at the preparer's request, have a hearing arranged and will have the preparer notified that such an administrative hearing will be held with regard to the alleged misconduct.
2. Should the preparer fail to deny or provide documentation or information to refute the allegations made against him within thirty (30) days after the date of the mailing of the initial letter to the preparer, such allegations will be deemed to be admitted, and the preparer will have waived his right of hearing. The Director of Provider Audit will then notify the preparer of his suspension under this rule.
3. The above described hearing will be set for a time no earlier than thirty (30) days after the date of the mailing of the initial letter to the preparer.

(c) Procedures Related to Informal Inquiry.

1. Notice. The initial notice from the Director of Provider Audit to the preparer will describe with sufficient specificity the allegations being made against him to allow him to respond to those allegations in a specific manner.
2. The Notice of Hearing. The notice of hearing to the preparer will repeat the allegations which constitute the basis for the proceedings and state the date, time, and place of the hearing. The hearing, as noted in Rule No. 560-X-56-.19(3)(b)1 above will be arranged only at the request of the preparer. Such notice shall be considered sufficient if it fairly informs the preparer of the allegations against him so that he is able to prepare his defense. Such notice may be mailed to the preparer by first class or certified mail, addressed to him at his last address known to the Director of Provider Audit. A response or correspondence from the preparer or his representative shall be mailed to Director of Provider Audit, Alabama Medicaid Agency at the Agency's current address.
3. Answer. No written answer to the notice of hearing shall be required of the preparer.
4. Hearing. The hearing shall be conducted in accordance with Medicaid's Regulations related to Fair Hearings. (Chapter 3 of the Alabama Medicaid Administrative Code.)
5. Failure to Appear. If the preparer fails to appear at the hearing after notice of the hearing has been sent to him, he shall have waived the right to a hearing and the Commissioner of Medicaid may make his or her determination without further proceedings.
6. Determination of ineligibility. The determination of the ineligibility of a Cost Report Preparer to prepare Medicaid cost reports will lie solely with the Commissioner of Medicaid. The Commissioner will make such determination after giving due consideration to the written recommendation of the Hearing Officer, unless the preparer has waived his right to hearing, in which event there need be no recommendation by the Hearing Officer.
7. Notification of Ineligibility. If the determination of the Commissioner is that the preparer shall no longer be eligible to prepare Medicaid cost reports, the preparer shall be notified in writing, and the preparer shall thereafter not be eligible to prepare such reports unless and until authorized by the Commissioner of Medicaid to do so. Such preparer shall IN NO EVENT be eligible to prepare such cost reports during the two (2) year period immediately following his suspension. Any person who acts as a Cost Report Preparer during his period of suspension shall not thereafter be eligible to act as a Cost Report Preparer for a period of ten (10) years from the date of his

original suspension. Any provider who knowingly allows a cost report to be prepared by a person who has been suspended under this Section will be subject to having its provider agreement cancelled and will be subject to the applicable penalties of Rule No. 560-X-56-.18 of this code.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 405.2401 - .2429. Rule effective April 15, 1993.

Chapter 57. Home and Community-Based Services for the State of Alabama Independent Living (SAIL) Waiver.

Rule No. 560-X-57-.01. Authority and Purpose.

(1) Home and community-based services for the SAIL Waiver are provided by the Alabama Medicaid Agency to disabled individuals who would otherwise require institutionalization in a nursing facility. These services are provided through a Medicaid waiver under the provisions of Section 1915(c) of the Social Security Act for an initial period of three years and for five year periods thereafter upon renewal of the waiver by the Centers for Medicare and Medicaid Services.

(2) The purpose of providing home and community-based services to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care.

Author: Patricia A. Harris, Administrator, LTC Program Management Unit
Statutory Authority: Section 1915(c) Social Security Act; 42 CFR 441, Subpart G. **History:** Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-57-.02. Eligibility.

(1) Financial eligibility is limited to those individuals receiving SSI, individuals receiving State Supplementation, SSI related protected groups deemed to be eligible for SSI/Medicaid, and Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate.

(2) Medical eligibility is determined based on current admission criteria for nursing facility level of care as described in Rule No. 560-X-10-.10.

(3) No waiver services will be provided to recipients in a hospital or nursing facility. However, case management activities are available to assist recipients interested in transitioning from an institution into a community setting. Case management activities to facilitate the transition are limited to a maximum of 180 days prior to discharge into the community.

(4) The Alabama Medicaid Agency or its operating agency, Alabama Department of Rehabilitation Services, acting on Medicaid's behalf may deny home and community-based services if it is determined that an individual's health and safety is at risk in the community; if the cost of serving an individual on the waiver exceeds the cost of caring for that individual in a nursing facility; if the individual does not cooperate with a provider in the provision of services; or if an individual does not meet the goals and objectives of being on the waiver program.

(5) The Alabama Medicaid Agency is restricted by the waiver to serving the estimated annual unduplicated number of beneficiaries approved by the Centers for Medicare and Medicaid Services.

(6) The eligibility age criteria is 18 years and above.

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based SAIL Waiver.

History: Rule effective June 12, 1992. Effective date of this amendment is February 10, 1994. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed June 20, 2008, effective September 15, 2008.

Rule No. 560-X-57-.03. Operating Agencies.

The Home and Community-Based SAIL Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Rehabilitation Services.

Author: Patricia A. Harris, Administrator, LTC Program Management Unit
Statutory Authority: The Home and Community-Based Homebound Waiver.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-57-.04. Covered Services.

(1) Case Management Services.

(a) Case management is a system of providing services which will assist waiver recipients in gaining needed waiver and other state plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained. Case management services may be used to locate, coordinate, and monitor necessary and appropriate services. Case management activities may also be used to assist in the transition of an individual from institutional settings prior to discharge into the community.

(b) Case managers are responsible for care plan development and ongoing monitoring of the provision of waiver services and nonwaiver services included in the recipient's care plan.

(c) Case management will be provided by a case manager employed by or under contract with the Department of Rehabilitation Services or any other Medicaid approved provider of waiver services that meets the qualifications of Nurse I or Rehabilitation Counselor.

(2) Personal Care Services.

(a) Personal care services are services that provide assistance with eating, bathing, dressing, personal hygiene and activities of daily living. Services may include assistance with preparation of meals but do not include the cost of meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

(b) Personal care services will be provided by individuals employed by a certified Home Health Agency or other health care agencies approved by the Commissioner of the Alabama Medicaid Agency and supervised by a case manager. Persons providing personal care services must meet the qualifications of a personal care attendant and meet provider performance standards.

(c) Personal care services may be provided by family members or friends only if lack of other qualified providers in applicable remote areas exists. Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child or to a recipient's spouse if qualified providers are in the area. Payment will not be made for services furnished to a recipient by their child, the recipient's spouse or to a minor by a parent (or stepparent).

(d) Services provided to each client are dependent on individual need as set forth in the client's plan of care. Personal care services may not exceed 25 hours per week and may not exceed

1300 hours per waiver year (April 1 – March 31). Medicaid will not reimburse for activities which are not within the Scope of Services.

(3) Environmental Accessibility Adaptations

(a) Environmental accessibility adaptations provide those physical adaptations to the home required by the individual's plan of care which are necessary to ensure the health, welfare, and safety of the individual or which enable the individual to function with greater independence in the home and without which the individual would require institutionalization. The service may also be provided to assist an individual to transition from an institution to the SAIL Waiver, but should not be billed until the first day the client is active on the waiver. Adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as floor covering, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home or permanent adaptations to rental property are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.

(b) Environmental accessibility adaptations will be provided by individuals capable of constructing or installing the needed apparatus. Any construction/installation completed must be in accordance with state and local building codes.

(c) Environmental accessibility adaptations must be prior authorized and approved by the Alabama Medicaid Agency or its designee for prior authorization and must be listed on the client's plan of care. Any expenditure in excess of the maximum allowed amount must be approved by the State Coordinator and the Medicaid designated personnel.

(4) Personal Emergency Response System.

(a) Personal Emergency Response System (PERS) is an electronic service which enables certain high-risk patients to secure help in the event of an emergency. The client may also wear a portable "help" button which will allow for mobility. The system is connected to a patient's phone and programmed to signal a response center once a patient's "help" button is activated.

(b) PERS must be provided by trained professionals. The PERS staff must complete a two-week training period for familiarization with the monitoring system and proper protocol to provide appropriate response action.

(c) Initial setup and installation of PERS must be on the individual's plan of care, prior authorized and approved by the Alabama Medicaid Agency or its designee.

(5) Medical Supplies.

(a) Medical supplies include devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, to maintain health and safety in the home environment, or to perceive, control, or communicate with the environment in which they live. All waiver medical supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care.

(b) Providers of this service will be only those who have signed provider agreements with the Alabama Medicaid Agency and the Department of Rehabilitation Services.

(c) Medical supplies service shall not exceed $1,800.00 annually per recipient.

(6) Minor Assistive Technology

(a) Minor Assistive Technology (MAT) includes supplies, devices, controls or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. Minor Assistive Technology is necessary to maintain the recipient's health, safety and welfare and to prevent further deterioration of a condition.

(b) Providers of this service will be those who have a signed provider agreement with the Alabama Medicaid Agency and the Department of Rehabilitation Services. Vendors providing

MAT/devices should be capable of supplying and providing training in the use of the minor assistive technology/device.

(c) MAT shall not exceed the designated amount of $500.00 per recipient per waiver year.

(7) Assistive Technology.

(a) Assistive technology includes devices, pieces of equipment or products that are modified or customized which are used to increase, maintain or improve functional capabilities of individuals with disabilities. It also includes any service that directly assists an individual with a disability in the selection, acquisition or use of an assistive technology device. Such services may include evaluation of need, acquisition, selection, design, fitting, customizing, adaptation, application, etc. This service must be listed on the individual's care plan. Items reimbursed with waiver funds shall be in addition to any medical equipment furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. The service must be medically necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the SAIL Waiver. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate. All items shall meet applicable standards of manufacture, design and installation.

(b) Assistive technology and transitional assistive technology services must be prior authorized and approved by the Alabama Medicaid Agency, or its designee and must be listed on the client's plan of care.

(c) Assistive technology services will be provided by licensed individuals or businesses capable of supplying the needed equipment and/or supplies. Assistive technology must be approved by the Alabama Medicaid Agency and must be listed in the individual's plan of care. Providers of this service will be those who meet provider qualifications and who have a signed provider agreement with the Alabama Department of Rehabilitation Services. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.

(8) Assistive Technology Repairs

(a) Assistive technology repairs will provide for the repair of devices, equipment, or products that were previously purchased by the Alabama Medicaid Agency for the recipient. Repairs include replacement of parts or batteries to allow the equipment to operate.

(b) The provider should be responsible for replacement or repair of the equipment or any part thereof that is found to be nonfunctional because of faulty material or workmanship within the guarantee of the manufacturer without any charge to the recipient or the Alabama Department of Rehabilitation Services. Repairs outside the warranty period will be reimbursed by the operating agency.

(c) Businesses providing this service will possess a business license and also be required to give a guarantee on work performed.

(d) This service must be listed on the recipient Plan of Care before being provided.

(e) The maximum amount for this service is $2000.00 per recipient annually.

(9) Evaluation for Assistive Technology

(a) Evaluation for assistive technology will provide evaluations and determinations of a client's needs for equipment prescribed by a physician to promote health, safety, and prevent institutionalization or to assist an individual to transition from an institutional level of care to the SAIL Waiver. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

(b) The individual providing evaluation must be a physical therapist licensed to do business in the State of Alabama and enrolled as a provider with the Alabama Department of Rehabilitation Services. The physical therapist should not have any financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of assistive technology equipment/devices.

(c) A written copy of the physical therapist's evaluation must accompany the prior authorization request and a copy must be kept in the recipient's file. This service must be listed on the recipient's Plan of Care before being provided.

(10) Personal Assistance Service

(a) Personal assistance services (PAS) are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. These activities would be performed by the individual if that person did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform everyday activities. This service will support that population of individuals with physical disabilities who need services beyond personal care and primarily those seeking competitive employment either in their home or in an integrated work setting.

(b) Personal assistance services will be provided by a personal care attendant under the supervision of a registered nurse who meets the Personal Assistance Service staffing requirements. Individuals providing personal care services must meet the qualifications of a personal care attendant and meet provider performance standards.

(c) Personal assistance services may be provided by family members or friends only if lack of other qualified providers in remote areas exists. Under no circumstances will payment be made for services furnished to an adult disabled child by the parent, to a parent by their child or to a recipient's spouse if qualified providers are in the area. Payment will not be made for services furnished to a recipient by their child, the recipient's spouse or to a minor by a parent (or stepparent).

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based SAIL Waiver.
History: Rule effective June 12, 1992. Amended February 19, 1994; October 12, 1996. **Amended:** Filed March 20, 2001; effective June 15, 2001. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed September 20, 2007; effective December 14, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008. **Amended:** Filed March 20, 2009; effective June 16, 2009.

Rule No. 560-X-57-.05. Costs for Services.

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based Homebound Waiver. Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992.

Rule No. 560-X-57-.06. Application Process.

(1) The case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community based services. For institutional residents residing in a facility for at least 90 days who are interested in transitioning into the community, the case manager should thoroughly review referrals and intake information. This process will take place during the 180 consecutive day transition period.

(2) An initial assessment will be completed by the case manager in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the operating agency, Alabama Department of Rehabilitation Services (ADRS), for approval.

(3) The case manager, in conjunction with the applicant's physician, client and/or caregiver will develop a Plan of Care. The Plan of Care will include objectives, services, provider of services, and frequency of service. Changes to the original Plan of Care are to be made as needed to adequately care

for an individual. Reasons for changes must be documented on the client's care plan which is subject to the review of the Alabama Medicaid Agency. The Plan of Care must be reviewed by the case manager as often as necessary and administered in coordination with the recipient's physician.

(4) The Alabama Medicaid Agency has delegated the medical level of care determination to qualified trained individuals at ADRS.

(5) Medicaid requires the providers to submit an application in order to document dates of service provision to long term care recipients.

(a) The long term care file maintains these dates of service.

(b) The applications will be automatically approved through systematic programming.

(c) The Alabama Medicaid Agency will perform random audits on a percentage of records to ensure that documentation supports the medical level of care criteria, physician certification, as well as other state and federal requirements.

(6) ADRS is responsible for the assessment, evaluation of admissions, readmissions, and annual redeterminations for eligible participants receiving home and community-based services in accordance with the provisions of the SAIL Waiver.

(7) The Alabama Medicaid Agency will provide to ADRS the approved Level of Care criteria and policies and procedures governing the level of care determination process.

(8) ADRS will designate a qualified medical professional to approve the level of care and develop the Plan of Care.

(9) Admissions, readmissions and annual redeterminations must be certified by a physician licensed to practice in Alabama.

(10) ADRS may utilize Medicaid staff for consultation on questionable admissions and annual redeterminations prior to a final decision being rendered.

(11) The Alabama Medicaid Agency will conduct a monthly retrospective review of a random sample of individuals served under the SAIL Waiver to determine appropriate admissions and annual redeterminations. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

(12) The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal, medical necessity, and eligibility requirements are not met.

(13) The Alabama Medicaid Agency may seek recoupment from ADRS for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for SAIL Waiver services or Medicaid eligibility but for the certification of waiver eligibility by ADRS.

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the SAIL Waiver.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed May 20, 2003; effective August 21, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-57-.07. Financial Accountability of Operating Agency.

(1) The financial accountability of the operating agency for funds expended on Home and Community-Based services must be maintained and provide a clearly defined audit trail. The operating agency as described in the waiver document must retain records that fully disclose the extent and cost of services provided to eligible recipients for a five-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the state of Alabama, the operating agency will pay the travel cost of the auditors to the location of the records.

(2) The operating agency may have their records audited annually at the discretion of the Alabama Medicaid Agency. Payments that exceed actual allowable cost will be recovered by Medicaid.

(3) The Alabama Medicaid Agency will review at least annually recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

(4) The operating agency will provide documentation of actual costs of services and administration. Such documentation will be entitled "Quarterly Cost Report" for the SAIL Waiver. The "Quarterly Cost Report" will include all actual costs incurred by the operating agency for the previous quarter and include costs incurred year to date. This document will be submitted to the Alabama Medicaid Agency before the 1st day of the third month of the next quarter. Quarters are defined as follows:

(a) 1st April -June
Due before September 1

(b) 2nd July-September
Due before December 1

(c) 3rd October-December
Due before March 1

(d) 4th January-March
Due before June 1

Failure to submit the actual cost documentation may result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed. Quarterly cost reports will be reviewed to determine necessity for a field audit.

(5) Auditing Standards - Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State and Local Governments" will apply to governmental agencies participating in this program. For non-governmental agencies, generally accepted accounting principles will apply. Governmental and non-governmental agencies will utilize the accrual method of accounting unless otherwise authorized by the Alabama Medicaid Agency.

(6) Cost, Allowable and Unallowable.

(a) 45 C.F.R., part 95, specifies dollar limits and accounting principles for the purchase of equipment. Purchases above the twenty-five thousand dollar limit require the approval of Medicaid.

(b) OMB Circular A-87 establishes cost principles for governmental agencies and will serve as a guide for non-governmental agencies. For governmental agencies, all reported cost will be adjusted to actual cost at the end of the waiver year.

(c) Contract payments for the delivery of specific services are allowable expenses. Thus, contracts for case management, personal care, respite care, environmental accessibility adaptations,

assistive technology, and medical supplies are recognized expenses. All other contracts will require Medicaid approval to insure that functions are not being duplicated. For example, outreach is to be performed by the case manager, thus, it would not be appropriate to approve other contracts for outreach, unless it can be clearly shown that the function is required and cannot be provided within the established organization.

(d) Allowable costs are defined in OMB Circular A-87. However, the following restrictions apply:

1. Advertising is recognized only for recruitment of personnel, solicitation of bids for services or goods, and disposal of scrap or surplus. The cost must be reasonable and appropriate.

2. The cost of buildings and equipment is recognized. For governmental agencies, buildings and equipment exceeding twenty-five thousand dollars will be capitalized in accordance with 45 C.F.R. 95.705 and depreciated through a use allowance of two percent of acquisition cost for building and six and two-thirds percent for equipment. Equipment that has a remaining value at the completion of the project will be accounted for in accordance with 45 C.F.R. 95.707. For automated data processing equipment, see 45 C.F.R. 95.641. When approval is required, the request will be made to Medicaid Agency in writing.

3. The acquisition of transportation equipment will require prior approval from the Alabama Medicaid Agency. When approval is required, the request will be made to Medicaid in writing.

4. Transportation is an allowable expense to be reimbursed as follows:

(i) For non-governmental agencies, it will be considered as part of the contract rate.

(ii) For government and private automobiles utilized by state employees, reimbursement will be made at no more than the current approved state rate.

(iii) All other types of transportation cost will be supported by documents authorizing the travel and validating the payment.

(e) Unallowable costs are specified in OMB Circular A-87. In addition to these, the following are not covered by this program:

1. Costs covered by other programs, such as:

(i) Prescription drugs,

(ii) Dental expenses,

(iii) Ambulance service,

(iv) Inhalation, group, speech, occupational, and physical therapy.

(v) Non-emergency transportation

2. The cost of advisory councils or consultants without Alabama Medicaid Agency's approval.

3. Legal fees as follows:

(i) Retainers,

(ii) Relating to fair hearings,

(iii) In connection with law suits, which result in an adverse decision,

(iv) Services that duplicate functions performed by Medicaid or the provider, such as eligibility determination for the program,

(v) Other legal fees not relating to the providing of services to the beneficiaries.

4. Dues and subscriptions not related to the specific services.

(7) Cost Allocation Plans.

(a) State agencies are required to have a cost allocation plan approved by the Division of Cost Allocation (DCA) when the agencies handle multiple federal funds. The format of a cost allocation plan is specified by 45 C.F.R. 95.507, which also calls for written agreements between state agencies. Existence of such a plan will be an item of audit.

(b) Direct costs are charged to the specific services that incurred them. It is the indirect/overhead costs that are allocated to the specific fund. If there is more than one project within a fund, there must be a written plan to distribute fund costs among the projects. Within this project, there are two types of indirect costs. The first are those that can be associated with the services that are provided, such as an assessment at the central office that verifies the quality of service. This cost can be

prorated to each service by some method that is described in writing. This first type of cost qualifies for the federal match benefit percentage.

The second type of allocated cost falls under the administration definition. For example, a case manager that spends time on two individuals (or group of people) that have not attained waiver eligibility. This second type has a federal match of 50/50; therefore, both types must be accounted for separately.

(c) Contracts which are used for procuring services from other governmental agencies must be cost-allocated. As a minimum, these contracts should meet the requirements of 45 C.F.R. 95.507; these contracts must indicate:

1. The specific services being purchased.
2. The basis upon which the billing will be made -- (e.q., time reports, number of homes inspected, etc.).
3. A stipulation that the billing will be based on actual costs incurred. This is not a requirement for non-governmental agencies. For governmental agencies, the billing should be either actual cost or an agreed upon fixed fee approximating actual cost which will be adjusted to actual cost at completion of the waiver year.

Author: Sigrid Laney, Associate Director, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 441, Subpart G and the SAIL Waiver.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of the amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007.

Rule No. 560-X-57.-08. Fair Hearings.

(1) An individual whose application to the Waiver Program is denied based on financial eligibility may request a hearing through the appropriate certifying agency.

(2) An individual who is denied home and community-based services based on medical criteria, may request a fair hearing through the Alabama Medicaid Agency, Long Term Care Division.

Author: Patricia A. Harris, Administrator, LTC Program Management Unit.
Statutory Authority: 42 CFR Section 431, Subpart E.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003.

Rule No. 560-X-57.-09. Appeal Procedure for Medicaid Fiscal Audits.

(1) Fiscal audits of the SAIL Waiver Services are conducted by the Provider Audit Division of Medicaid. At the completion of the field audit there will be an exit conference with the operating agency to explain the audit findings. The operating agency will have the opportunity to express agreement or disagreement with the findings. The field audit and the comments of the operating agency are reviewed by the Associate Director of the Provider Audit Division and a letter is prepared making the appropriate findings official. If the operating agency deems that the findings are not justified, they may request an informal conference with the Director of the Provider Audit Division.

To request the informal conference, the operating agency must submit a letter within thirty days from the date of the official audit letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to:

ATTN: Director

Provider Audit Division
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

The decisions of the Director, Provider Audit Division made as a result of the informal conference will be forwarded to the operating agency by letter. If the operating agency believes that the results of the informal conference are still adverse, they will have 15 days from the date of the letter to request a fair hearing.

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 431, Subpart E.
History: Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992. Effective date of this amendment is October 12, 1996. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-57-.10. Payment Methodology for Covered Services.

(1) Payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

(2) For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month, but no single claim can cover services performed in different months. If the submitted claim covers dates of service, part or all of which were covered in a previously paid claim, it will be rejected. Payment will be based on the number of units of service reported for each procedure code listed in the Medicaid Provider Manual.

(3) The rate will be based on audited past performance with consideration being given to the medical care portion of the consumer price index and renegotiated contracts. Interim fees may be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

(4) All claims for services must be processed within six months after end of waiver year. At the end of the waiver year, the operating agency will be audited and a final rate will be calculated based on actual allowable cost for the year divided by the number of services provided during the year. Any difference between the actual allowable cost and the revenues received based on the interim rate will be adjusted.

(5) Accounting for actual cost and units of services provided during a waiver year must be accomplished on CMS-372 reports. The following accounting definitions will be used in establishing new interim fees:

(a) A waiver year consists of the 12 months following the start of any waiver year.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public (governmental) provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the State agency.

(c) The services provided are reported and paid by dates of service. Thus, all services provided during the 12 months of the waiver year will be attributed to that year.

(6) Provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the cost. The administrative portion will be divided into 12 equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver year is audited, this cost,

like the benefit cost, will be determined and a lump sum settlement will be made to adjust that year's payments to actual cost.

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit.
Statutory Authority: 42 CFR Section 441, Subpart G and the Home and Community-Based SAIL Waiver.
History: Rule effective June 1992. Amended February 10, 1994, and October 12, 1996. **Amended:** Filed February 19, 1999; effective April 12, 1999. **Amended:** Filed March 20, 2001; effective June 15, 2001. **Amended:** Filed April 21, 2003; effective July 16, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-57-.11. Third Party Liability.

(1) The Third Party Division, Alabama Medicaid Agency, is responsible for fulfilling the requirements pertaining to third party liability. The purpose of the Third Party Division is to insure that Medicaid is the last payor. Providers shall make all reasonable efforts to determine if there is a liable third party source, including Medicare, and in the case of a liable third party source, utilize that source for payments. Third party payments received after billing Medicaid for service for a Medicaid recipient shall be refunded to the Alabama Medicaid Agency within sixty days of receipt of Medicaid payment. For further information concerning Third Party Liability refer to Administrative Code Chapter 20.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Sections 22-6-6 of 1975 Code of Alabama. Emergency Rule effective April 1, 1992. Effective date of this Rule is June 12, 1992.

Rule No. 560-X-57-.12 Confidentiality.

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon written consent of the recipient, his or her attorney, and/or guardian, or upon subpoena from a court of appropriate jurisdiction.

Author: Latonda Cunningham, Administrator, LTC Project Development/Program Support Unit
Statutory Authority: 42 CFR Section 431.306.
History: New Rule: Filed April 21, 2003; effective July 16, 2003.

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Chapter 58. Home and Community-Based Services for Individuals Diagnosed with HIV/AIDS and Related Illness

Rule No. 560-X-58-.01. Authority and Purpose.

(1) Home- and community-based services for individuals diagnosed with HIV/AIDS or related illness are provided by the Alabama Medicaid Agency to persons who are Medicaid-eligible under the waiver and who would, but for the provision of such services, require the level of care available in a nursing facility. These services are provided through a Medicaid waiver under provisions of the Omnibus Budget Reconciliation Act of 1981, which added Section 1915(c) to the Social Security Act, for an initial period of three (3) years and renewal periods of five (5) years thereafter upon waiver approval by the Centers for Medicare and Medicaid Services (CMS).

(2) The Operating Agency for the HIV/AIDS Waiver is the Alabama Department of Public Health. The Operating Agency is responsible for the day-to-day operations of the waiver program. This includes managing the program by focusing on improving care for the client, protecting the health and welfare of the client, giving the client free choice of providers and waiver service workers, and making sure all direct service providers meet the qualifications as outlined in the waiver document.

(3) Home and community-based services covered in this waiver are Case Management, Homemaker Services, Personal Care, Respite Care, Skilled Nursing and Companion services. These services provide assistance necessary to ensure optimal functioning of individuals diagnosed with HIV/AIDS and related illness.

Author: Wanda J. Davis, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007.

Rule No. 560-X-58-.02. Description of Services.

Home and Community-Based Services are defined as Title XIX Medicaid-funded services provided to individuals diagnosed with HIV/AIDS or persons with related conditions who, without these services, would require services in a nursing facility. These services will provide health, social, and related support needed to ensure optimal functioning of the individual within a community setting. The operating agency may provide or subcontract for any services provided in this waiver. To qualify for Medicaid reimbursement each individual service must be necessary to prevent institutionalization. Each provider of services must have a signed provider contract, meet provider qualifications and comply with all applicable state and federal laws and regulations. The specific services available as part of the HIV/AIDS Waiver are:

(1) Case Management Services.

(a) Case management is a system of providing services which will assist waiver recipients in gaining access to needed, and desired waiver and other state plan services, as well as needed medical, social, educational and other services, regardless of the funding sources for the services to which access is gained. Case management services may be used to locate, coordinate, and monitor necessary and appropriate services. Case management activities may also be used to assist in the transition of an individual from institutional settings for up to 180 days prior to discharge into the community.

(b) Case managers are responsible for care plan development and ongoing monitoring of the provision of services included in the recipient's care plan.

(c) Case management will be provided by a case manager employed by or under contract with the state agency as specified in the approved waiver document. The case manager must meet the qualifications as specified in the approved waiver document.

(2) Homemaker Services.

(a) Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning, and personal services. The service is provided by a trained homemaker when the individual responsible for these activities is temporarily absent or unable to manage the home and care for himself.

(b) A person providing homemaker services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

(c) Medicaid will not reimburse for activities performed which are not within the scope of services.

(d) No payment will be made for services not documented on the Plan of Care and the Service Authorization Form. Payments rendered for services not present on the individual's Plan of Care will be recovered.

(3) Personal Care

(a) The objective of the Personal Care (PC) Service is to restore, maintain, and promote the health status of clients through home support, health observation, and support of and assistance with activities of daily living.

(b) PC Service provides assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair, ambulation, maintaining continence and other activities of daily living (ADLs).

(c) PC may include assistance with independent activities of daily living (IADLs) such as meal preparation, but does not include the cost of the meals themselves, using the telephone, and household chores such as laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

(4) Respite Care—Skilled and Unskilled

(a) The objective of Respite Care is to provide temporary care for clients who live at home and are cared for by their families or other informal support systems.

(b) This service will provide temporary, short-term relief for the primary caregiver, and continue the supervision and supportive care necessary to maintain the health and safety of waiver clients. Respite Care is intended to supplement, not replace care provided to waiver clients.

(c) Skilled or Unskilled Respite is provided to clients who have a physical, mental, or cognitive impairment that prevents them from being left alone safely in the absence of the primary caregiver.

(d) The number of units and services provided to each client is dependent upon the individual client's need as set forth in the client's POC established by the Case Manager if case management is elected by the client. In-home Respite Service may be provided for a period not to exceed 720 hours per waiver year in accordance with the provider contracting period. This limitation applies to skilled and unskilled respite or a combination. Medicaid will not reimburse for activities performed which are not within the scope of services defined.

(5) Skilled Nursing

(a) The Skilled Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and the Alabama State Board of Nursing.

(b) Skilled nursing under the waiver will not duplicate skilled nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Skilled Nursing under the waiver is utilized.

(6) Companion Services

(a) Companion Service is non-medical assistance, observation, supervision and socialization, provided to a functionally impaired adult.

(b) Companions may provide limited assistance or supervise the individual with such tasks as activities of daily living, meal preparation, laundry and shopping, but do not perform these activities as discrete services.

(c) The Companion may also perform housekeeping tasks which are incidental to the care and supervision of the individual.

(d) Companion Service is provided in accordance with a therapeutic goal as stated in the Plan of Care, and is not purely recreational in nature.

(e) The therapeutic goal may be related to client safety and/or toward promoting client independence or toward promoting the mental or emotional health of the client.

(f) Companion Services are only available to recipients who live alone and may not exceed four hours daily.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-58-.03. Eligibility.

(1) Financial eligibility is limited to those individuals receiving SSI, deemed to be receiving SSI and optional categorically needy at a special income level of 300 percent of FBR, State Supplementation, individuals eligible for the Pickle program (continued Medicaid); deemed disabled widow and widowers from age 50 but not yet age 60; early widow and widowers age 60-64; disabled adult children who lose Supplemental Security Income benefits upon entitlement to or an increase in the child's insurance benefits based on disability; those individuals who would be eligible for SSI if not for deeming of income of parent(s) or a spouse; and Medicaid for Low Income Families (MLIF).

(2) Medical eligibility is determined based on current admission criteria for nursing facility level of care as described in Rule No. 560-X-10-.10. In addition, waiver services are limited to individuals age 21 and over, who have been diagnosed with HIV/AIDS or related illness.

(3) No waiver services will be provided to recipients in a hospital or nursing facility. However, case management activities are available to assist recipients interested in transitioning from an institution into a community setting. Case management activities to facilitate the transition are limited to a maximum of 180 days.

(4) The Alabama Medicaid Agency may deny home and community-based services if it is determined that an individual's health and safety is at risk in the community; if the individual does not cooperate with a provider in the provision of services; or if an individual fails to meet the goals and objectives of being on the waiver program.

(5) Financial determinations and redeterminations shall be made by the Alabama Medicaid Agency, the Alabama Department of Human Resources or the Social Security Administration, as appropriate. In addition to the financial and medical eligibility criteria, the Alabama Medicaid Agency is restricted by the waiver to serving the estimated annual unduplicated number of beneficiaries approved by CMS.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.

History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed December 17, 2007; effective March 17, 2008. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-58-.04 Costs for Services.

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-58.-05 Application Process.

(1) Case managers will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community-based services.

(2) The case manager will complete a needs assessment to assist with the development of the Plan of Care. The medical information obtained from the client's primary physician is considered in development of the plan. This document will reflect detailed information regarding social background, living conditions and medical problems of the applicant. A copy of this document will be submitted to the Operating Agency for review and approval.

(3) The case manager, in conjunction with the client, family or legal representative, if applicable, and other person designated by the client will develop a participant-centered Plan of Care. The Plan of Care will include objectives, services, providers of services and frequency of service. The Plan of Care must be submitted to the Operating Agency for approval. Changes to the original Plan of Care should be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's Plan of Care, which is subject to the review of the Operating Agency. The Plan of Care must be reviewed by the case manager as often as necessary and administered in coordination with the recipient's physician.

(a) If the ADPH RN determines that the documentation does not support the individual's need for the level of care as determined by the case manager and the attending physician, the documentation will then be forwarded to the Alabama Medicaid Agency's Long Term Care Admissions/Records Unit for nurse review and further review by the Alabama Medicaid Agency's staff physician.

(b) The Alabama Medicaid Agency's staff physician will make the final decision to approve or deny waiver admission based upon the documentation provided. If a denial is issued, the recipient will receive a notice informing them of his/her right to an informal conference and/or a fair hearing.

(4) The Medicaid's Long Term Care Division will perform a retrospective review of a random sample of approved applications on a monthly basis. The purpose of this review is to ensure compliance with both state and federal guidelines. If problems are identified the operating agency will be notified in writing within 30 days of receipt of the documentation by the Alabama Medicaid Agency. A corrective action plan will be requested. Results of the audit may lead to recoupment of funds.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.

Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-58-.06. Informing Beneficiaries of Choice.

(1) The case manager will be responsible for ensuring that applicants of the waiver service program are advised of the feasible service alternatives and be given a choice of which type of service—institutional or home and community-based services—they wish to receive.

(2) Residents of long-term care facilities, and/or a designated responsible party with authority to act on the applicant's behalf, for whom home and community-based services become a feasible alternative under this waiver will be advised of the alternative at the time of review.

(3) All applicants determined to be eligible for home and community-based services will be offered the alternative. Provisions for fair hearings for all persons ineligible for services under this waiver will be made known to potential eligibles in accordance with Fair Hearings Procedures in the Alabama Medicaid Program.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed January 22, 2007; effective April 18, 2007. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-58-.07 Fair Hearings.

(1) An individual whose application to the waiver program is denied based on Rule No. 560-X-58-.03, may request a fair hearing in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code.

(2) Applicants will be given at least a ten-day notice before termination of service.

(3) A written request for a hearing must be received by the Alabama Medicaid Agency within 60 days following notice of action with which an individual is dissatisfied.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 431, Subpart F.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-58-.08. Payment Methodology for Covered Services.

(1) Payments made by Medicaid to providers will be on a fee-for-service basis. Each covered service is identified on a claim by a procedure code.

(2) For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however no single claim can cover services performed in different months. For example, a claim with dates of service of 5/15/03 to 6/15/03 is not allowed. If the submitted claim covers any dates of service which were covered in a previously paid claim, the claim will be rejected.

(3) Payment will be based on the number of units of service reported on the claim for each procedure code.

(4) Accounting for actual cost and units of services provided during a waiver year must be captured on CMS Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

(a) A waiver year consists of 12 consecutive months starting with the approval date specified in the approved waiver document.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the state agency.

(c) The services provided by a direct service provider agency is reported and paid by dates of service. Thus, all services provided during the 12 months of the waiver year will be attributed to that year.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-58-.09. Confidentiality.

Providers shall not use or disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon the written consent of the recipient, his/her attorney or legal representative, or upon subpoena from a court of appropriate jurisdiction.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 431.306, Subpart F—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-58-.10. Records.

(1) The Alabama Department of Public Health shall make available to the Alabama Medicaid Agency (AMA) at no charge, all information regarding claims submitted and paid for services provided eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. Said records shall be retained for the period of time required by state and federal laws.

(2) A sign-in log, service receipt, or some other written record shall be used to show the date and nature of services; this record shall include the Recipient's signature or designated signature authority.

(3) Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a five-year period. These records must be accessible to the AMA and appropriate state and federal officials.

(4) There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The AMA and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

Author: Melody Tompkins, Program Manager, LTC Policy Advisory Unit.
Statutory Authority: Social Security Act §1915(c); 42 C.F.R. Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed June 20, 2008; effective September 15, 2008.

Rule No. 560-X-58-.11. Service Providers.

The Home and Community-Based HIV/AIDS Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Public Health.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-58-.12. Enrollment.

(1) Medicaid's fiscal agent enrolls providers of waiver services and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations and the *Alabama Medicaid Provider Manual*.

(2) General enrollment instructions and information can be found in Chapter 2, "Becoming a Medicaid Provider", of the *Alabama Medicaid Provider Manual*. Failure to provide accurate and truthful information or intentional misrepresentation may result in action ranging from denial of application to permanent exclusion and criminal prosecution.

Author: Felecia Barrow, Associate Director, LTC Project Development Unit.
Statutory Authority: Social Security Act §1915(c); 42 CFR Section 441, Subpart G—Home and Community-Based Services: Waiver Requirements.
History: New Rule: Filed June 20, 2003; effective September 15, 2003.

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Chapter 59. Provider-Based Rural Health Clinic Services

Rule No. 560-X-59-.01 General.

(1) A Provider-Based Rural Health Clinic (PBRHC) is a rural health clinic that is an integral and subordinate part of a hospital, skilled nursing facility, or a home health agency participating in Medicare and is operated with other departments of the provider under common licensure, governance, and professional supervision.

(2) Provider-Based Rural Health Clinics' claim(s) filing limit shall be 365 days from date of service. Claims received after this time limit will be treated as outdated in accordance with Rule 560-X-1-.17.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: 42 C.F.R. Section 405.2401-.2472, Section 447.371. Section 702, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.
History: Emergency rule effective October 1, 1993. Rule effective December 14, 1993. Amended: Emergency Rule filed and effective March 20, 2001. **Amended:** Filed March 20, 2001; effective June 15, 2001.

Rule No. 560-X-59-.02 Participation.

(1) In order to participate in the Title XIX (Medicaid) Program, and to receive Medicaid payment, a Provider-Based Rural Health Clinic, including satellite clinics must:

(a) request an enrollment packet from our Fiscal Agent Provider Enrollment Unit ;
(b) be certified for participation in the Title XVIII (Medicare) Program;
(c) obtain certification by the appropriate State survey agency;
(d) be in compliance with the Clinical Laboratory Improvement Amendment (CLIA) testing for all laboratory sites; and
(e) be operating in accordance with applicable Federal, State and local laws.

(2) Requests for enrollment in the Alabama Medicaid Program must be sent to the Fiscal Agent Provider Enrollment Unit.

(3) Satellite clinics must enroll separately and execute a separate provider contract with Alabama Medicaid.

(4) The effective date of enrollment of a Provider-Based Rural Health Clinic will be the date of Medicare certification but under no circumstance will the date be earlier than October 1, 1993. Providers who request enrollment more than 120 days after certification are enrolled on the first day of the month the enrollment is approved.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: 42 C.F.R. Section 491 Subpart A; Section 405.2401-.2472 Subpart X; Title XIX; Clinical Laboratory Improvement Amendment of 1988 (CLIA) 42CFR Section 493 et seq.; Public Law 100-578 (42 U.S.C. Section 263a); State Plan Attachment 4.19-B.
History: Emergency rule effective October 1, 1993. Permanent rule effective December 14, 1993.
Amended: Filed January 18, 2002, effective April 18, 2002.

Rule No. 560-X-59-.03 Provider-Based Rural Health Services.

(1) Services covered in the Provider-Based Rural Health Clinic are:

(a) Medically necessary diagnostic and therapeutic services and supplies that are an incident to such services or as an incident to a physician's service and that are commonly furnished in a physician's office or a physician home visit;

(b) Basic laboratory services essential to the immediate diagnosis and treatment of the patient that must include but are not limited to the six (6) tests that must be provided directly by the rural health clinic:

1. Chemical examinations of urine by stick or tablet methods or both (including urine ketones)
2. Hemoglobin or hematocrit
3. Blood glucose
4. Examination of stool specimens for occult blood
5. Pregnancy tests, and
6. Primary culturing for transmittal to a certified laboratory

(c) Medical emergency procedures as a first response to life threatening injuries and acute illness.

(2) Provider-Based Rural Health Services may be provided by a:

(a) Physician; or

(b) Physician assistant, nurse practitioner, certified nurse midwife, or a specialized nurse practitioner as an incident to a physician's service.

(3) A physician, physician assistant, nurse practitioner, certified nurse midwife, and specialized nurse practitioner must conform to all State requirements regarding the scope or conditions of their practice.

(4) A nurse practitioner, physician assistant, certified nurse midwife, or a specialized nurse practitioner must furnish patient care services at least 50 percent of the time the clinic operates.

(5) The Provider-Based Rural Health Clinic must be under the medical direction of a physician. Except in extraordinary circumstances, the physician must be physically present for sufficient periods of times, at least every 72 hours for non-remote sites and every seven (7) days for remote sites (a remote site being defined as a site more than 30 miles away from the primary supervising physician's principal practice location), to provide medical care services, consultation, and supervision in accordance with Medicare regulations for Rural Health Clinics. When not physically present, the physician must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances must be documented in the records of the clinic.

(6) The Provider-Based Rural Health Clinic must have in effect agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to its patients, including physician services provided in the inpatient hospital setting, the office, the patient's home, or a skilled nursing facility. If the agreements are not in writing there must be evidence that patients referred by the clinic are being accepted and treated.

(7) Rural Health Clinic visits and inpatient physician services are subject to the same routine benefit limitations as for physicians. Refer to Chapter 6 of the Administrative Code for details.

Arthur: Ginger Collum, Program Manager, Clinic/Ancillary Services
Statutory Authority: State Plan, Attachment 3.1-A, Pages 1.2 and 2.3a; 42 C.F.R. Section 491 Subpart A; Section 491.8(a), Section 491.9(2), Section 405.2401-.2472 Subpart X; Section 410.45; Section 440.10-.20.
History: Emergency rule effective October 1, 1993. Permanent rule effective December 14, 1993. Amended March 14, 1996, August 11, 1997. Amended: Filed January 18, 2002, effective April 18, 2002.

Amended: Filed July 21, 2003; effective October 16, 2003.

Rule No. 560-X-59-.04 Other Ambulatory Services.

(1) The following services are covered as other ambulatory services furnished in a Provider-Based Rural Health Clinic and are considered rural health clinic services:

(a) Dental services;
(b) Eyeglasses;
(c) Hearing Aids;
(d) Prescribed devices;
(e) Prosthetic devices;
(f) Durable medical equipment;
(g) Family Planning;
(h) Prenatal;
(i) EPSDT (Early and Periodic Screening, Diagnosis and Treatment); and
(j) Preventive Health Education.

(2) The services listed in Rule No. 560-X-59-.04 (1) are subject to billing, policies, and routine benefit limitations for the designated program area(s). Refer to the Administrative Code Chapters 15, 17, 19, 13, 14, 43, 11, and 50 respectively for procedures and policies.

Authority: State Plan, Attachment 3.1-A, Page 1.2; 42 C.F.R. Section 440.10-.20, Section 447.371. Emergency rule effective October 1, 1993. Permanent rule effective December 14, 1993.

Rule No. 560-X-59-.05 Reimbursement.

(1) Provider-Based Rural Health Clinics will be reimbursed under a prospective payment system as described in Section 1902(aa) of the Social Security Act. Refer to Alabama Administrative Code Chapter 60.

(2) Inpatient and outpatient surgery is reimbursed as fee for service and is subject to the routine benefit limitations and policies as stated in Chapter 6 of the Administrative Code.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: State Plan, Attachment 4.19-B, page 1; 42 C.F.R. Section 405.2401-.2472, Section 410.152, Section 413 Subpart D, Section 447.371. Section 702, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.
History: Emergency rule effective October 1, 1993. Rule effective December 14, 1993. Amended January 12, 1995. Amended: Emergency Rule filed and effective March 20, 2001. Amended: June 15, 2001.
Amended: Filed January 18, 2002, effective April 18, 2002.

Rule No. 560-X-59-.06 Medicare Deductible and Coinsurance.

For Provider-Based Rural Health Clinic services, Medicare deductible and/or coinsurance will be reimbursed up to the full amount of the Medicaid encounter rate.

Author: Carol Akin, Associate Director, Clinic/Ancillary Services
Statutory Authority: State Plan, Attachment 4.19-B, page 10. 42 C.F.R. Section 405.2410; Section 413 Subpart D.
History: Emergency rule effective October 1, 1993. Permanent rule effective December 14, 1993.
Amended: Filed January 18, 2002, effective April 18, 2002.

Rule No. 560-X-59-.07 Change of Ownership.

The provider must notify Medicaid within thirty (30) days of the date of ownership change of a Provider-Based Rural Health Clinic. The existing contract will be automatically assigned to the new owner. The new owner shall then be required to execute a new contract with Medicaid as soon as possible after the change of ownership, but in no event later than thirty (30) days after the new owner receives notification of Medicare certification. If the new owner fails to execute a new contract with Medicaid within this time period; then the clinic's contract shall terminate.

Authority: 42 C.F.R. Section 405.2470, Section 405.2436-.2438. Emergency rule effective October 1, 1993. Permanent rule effective December 14, 1993.

Rule No. 560-X-59-.08 Copayment (Cost Sharing).

(1) Medicaid and Medicare/Medicaid related recipients are required to pay and Provider-Based Rural Health Clinics are required to collect the established copayment amount for each clinic visit.

(2) The cost-sharing requirement does not apply to services provided for the following:
- (a) Recipients under 18 years of age;
- (b) Emergencies;
- (c) Pregnancy;
- (d) Family Planning; and
- (e) Nursing home residents.

(3) A provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount.

Authority: 42 C.F.R. Section 447.50; Section 447.53; Section 447.55; State Plan, Attachment 4.18-A and 4.19-B. Emergency rule effective October 1, 1993. Permanent rule effective December 14, 1993.

Rule No. 560-X-59-.09 Billing Recipients.

(1) A provider agrees to accept as payment in full the amount paid by the State, plus any copayment amount required to be paid by the recipient, for covered items and further agrees to make no additional charge or charges for covered items to the recipient.

(2) A provider may bill the recipient for the copayment amount and for noncovered Medicaid services.

Authority: 42 C.F.R. Section 447.15; State Plan, Attachment 4.18-A. Emergency rule effective October 1, 1993. Permanent rule effective December 14, 1993.

Chapter 60. Provider Based Rural Health Clinic Reimbursement

Rule No. 560-X-60-.01. Provider Based Rural Health Clinic Reimbursement – Preface.

This Chapter states the Medicaid policy regarding Provider Based Rural Health Clinics (hereinafter referred to as PBRHCs) reimbursement and establishes the accepted procedures whereby reimbursement is made to PBRHC providers. Because of the length and complexity of this Chapter, it has been divided into sections to facilitate its utilization.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.02. Introduction.

This Chapter of the Alabama Medicaid Administrative Code has been published by the Alabama Medicaid Agency (Medicaid) to accommodate program needs and the administrative needs of PBRHCs and to help ensure that the reasonable cost regulations are uniformly applied state wide without regard to where covered services are furnished.

The Alabama Medicaid Program is administered by Medicaid under the direction of the Governor's Office. Reimbursement principles for PBRHC's are outlined in the following sections of this Chapter. These principles, hereinafter referred to as "Medicaid Reimbursement Principles," are a combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and principles and procedures published by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated PBRHC's. These principles are not intended to be all inclusive, and additions, deletions, and changes to them will be made by Medicaid as required. Providers are urged to familiarize themselves fully with the following information, as cost reports must be submitted to Medicaid in compliance with this Chapter and other provisions of the Medicaid Administrative Code.

If the Medicaid Administrative Code is silent on a given point, Medicaid will normally rely on appropriate OMB circulars (i.e., OMB A87, OMB 122, OMB 128, OMB 133), Medicare (Title XVIII) Principles of Retrospective Reimbursement and, in the event such Medicare Principles provide no guidance, Medicaid may impose other reasonability tests. The tests include, but are not limited to, such tests as:

Does the cost as reported comply with generally accepted accounting principles?

Is the cost reasonable on its own merit?

How does the cost compare with that submitted by similarly sized clinics furnishing like covered services?

Is the cost related to covered services and necessary to the operation of a clinic?

4. It is recognized that there are many factors involved in operating a PBRHC. Costs may vary from one facility to another because of scope of services, level of care, geographical location, and utilization. Considerable effort has been made to recognize such variables during the development of this Chapter. Only reported costs reflecting such variables without exceeding the "prudent buyer" concept or other applied tests of reasonability will be allowed by Medicaid. Implicit in the intention that actual costs be paid to the extent they are reasonable, is the expectation that the clinic seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer would pay for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

5. Records must be kept by the provider which document and justify costs, and only those costs which can be fully and properly substantiated will be allowed by Medicaid.

6. Unallowable costs which are identified during either desk audits or field audits will be disallowed despite similar costs having been included in prior cost reports without having been disallowed.
7. The only source of the funds expended by Medicaid is public funds, exacted from the taxpayers through state and federal taxes. Improper encroachment on these funds is an affront to the taxpayers and will be treated accordingly.
8. To assure only necessary expenditures of public money, it will be the policy of Medicaid to:

   Conduct on-site audits of facilities on an unannounced basis, although prior announcement may be made at the discretion of Medicaid.

   Determine audit exceptions in accordance with Medicaid Reimbursement Principles.

   Allow only non-extravagant, reasonable, necessary and other allowable costs and demand prompt repayment of any unallowable amounts to Medicaid.
9. In the event desk audits or field audits by Medicaid's staff reveal that a provider persists in including unallowable costs in its cost reports, Medicaid may refer its findings to the Medicaid Program Integrity Division, Medicaid Legal Counsel, and/or the Alabama Attorney General.
10. While the responsibility for establishing policies throughout the Medicaid Program rests with Medicaid, comments on the contents of this Chapter are invited and will be given full consideration.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.03. Definitions.

Accrual Method of Accounting - Revenues must be allocated to the accounting period in which they are earned and expenses must be charged to the period in which they are incurred. This must be done regardless of when cash is received or disbursed.

Chapter - This Chapter (Chapter Sixty) of the Alabama Medicaid Agency Administrative Code.

Costs Not Related to Patient Care - Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of efficiently operated patient care facilities and activities. Such costs are not allowable in computing reimbursable costs.

Costs Related to Patient Care - These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.

Cost Report- When used in this Chapter, means the document that was developed by the Alabama Medicaid Agency to report costs, charges, and revenues of the Provider Based Rural Health Clinics.

Covered Costs - Allowable direct and indirect costs that are reasonable and necessary in rendering covered health care services. To be recognized, costs (as indicated in the State Plan) must be identified in auditable accounting records and allocated on a reasonable basis between the delivery of covered type services and all other clinic activities.

Depreciation - That amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period of operation.

Fair Market Value - The bona fide price at which an asset would change hands or at which services would be purchased between a willing buyer and a willing seller, neither being under any compulsion to buy or sell and both having a reasonable knowledge of the relevant facts.

Fiscal Year - The 12 month period upon which providers are required to report their costs, also called the reporting period.

Fringe Benefits - Fringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death.

Full Time Equivalents (FTE) - The result of a calculation which determines the average number of employees per position working the customary work week full time.

HCFA - The Health Care Financing Administration, an agency of the U. S. Department of Health and Human Services.

Home Office Costs - See Rule 560-X-60-.10 for the in-depth discussion and treatment of home office costs.

Interest - Cost incurred for the use of borrowed funds.

(a) Necessary Interest - Incurred to satisfy a financial need of the provider on a loan made for a purpose directly related to patient care. Necessary interest cannot include loans resulting in excess funds or investments.

(b) Proper Interest - Must be necessary as described above, incurred at a rate not in excess of what a prudent borrower would have to pay in the money market at the time the loan was made, and incurred in connection with a loan directly related to patient care or safety.

(c) Interim Rate - A rate intended to approximate the provider's actual or allowable costs of services furnished until such time as actual allowable costs are determined.

Medicaid - The Alabama Medicaid Agency.

Medicaid Reimbursement Principles - A combination of generally accepted accounting principles, principles included in the State Plan, Medicare (Title XVIII) Principles of Reimbursement, and procedures and principles published by Medicaid to provide reimbursement of provider costs which must be incurred by efficiently and economically operated PBRHCs.

Necessary Function - A function being performed by an employee which, if that employee were not performing it, another would have to be employed to do so, and which is directly related to providing PBRHC services.

Pension Plans - A pension plan is a type of deferred compensation plan which is established and maintained by the employee primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement.

Proprietary Provider - Provider, whether a sole proprietorship, partnership, or corporation, organized and operated with the expectation of earning profit for the owners as distinguished from providers organized and operated on a nonprofit basis.

Provider - A person, organization, or facility who or which furnishes services to patients eligible for Medicaid benefits.

Provider Reimbursement Manual (HIM 15) - The title of the Medicare Provider Reimbursement Manual, a publication of HCFA.

Prudent Buyer Concept - The principle of purchasing supplies and services at a cost which is as low as possible without sacrificing quality of goods or services received.

Reasonable Compensation - Compensation of officers and/or employees performing a necessary function in a facility in an amount which would ordinarily be paid for comparable services by a comparable facility.

Reasonable Costs - Necessary and ordinary cost related to patient care which a prudent and cost-conscious businessman would pay for a given item or service.

Related - The issue of whether the provider and another party are "related" will be determined under (HIM 15) rules as to classification as "related" parties. (See Provider Reimbursement Manual).

Secretary - "Secretary" means the Secretary of Health and Human Services or his delegate.

Sick Leave - A benefit granted by an employer to an employee to be absent from their job for a stipulated period of time without loss of pay.

State Plan - The State Plan published by the State of Alabama under Title XIX of the Social Security Act Medical Assistance Program.

Trend Factors - A statistical measure of the change in costs of goods and services purchased by a PBRHC during the course of one year. The trend factors to be used for purposes of the Chapter shall be computed based upon the Health Care Costs - Regional Forecast and Regional Historical Tables - CPIU - Medical Care Services - East Southcentral Index, as published by Data Resources, Inc. (DRI).

Trend Factor Variance - During the rate setting period, the projected trend factor used in calculating the reimbursement rate for the prior year shall be compared to the actual trend factor. If the difference between the projected and actual trend factor was greater than one-half percent, an adjustment shall be made. If such adjustment is applicable, it shall be made by adding to or subtracting from the current trend factor.

Unallowable Costs - All costs incurred by a provider which are not allowable under the Medicaid Reimbursement Principles.

Vacation Costs - A vacation benefit is a right granted by an employer to an employee (a) to be absent from his job for a stipulated period of time without loss of pay or (b) to be paid an additional salary in lieu of taking the vacation.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.04 Reimbursement Methodology.

1. A Medicaid prospective payment system (PPS) for Provider Based Rural Health Clinics (PBRHCs) was enacted into law under section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. As described in section 1902(aa) of the Social Security Act, PBRHCs will be paid under a prospective payment system effective January 1, 2001. The rate setting period is from October 1 through September 30th.

2. Prior to enactment of BIPA PBRHCs were reimbursed by the ratio of cost to charges. With the implementation of BIPA, PBRHC providers that provided Medicaid covered services will submit a cost report with their normal year end for the cost report period ending in 2000. This cost report will be settled. For the period January 1, 2001, through September 30, 2001, Alabama Medicaid Agency will pay PBRHCs 100% of the average of their reasonable costs of providing Medicaid covered services during FY 1999 and FY 2000, adjusted to take into account any increase (or decrease), see paragraph (4) below, in the scope of services furnished during FY 2001 by the PBRHC (calculating the payment amount on a per visit basis). Beginning in FY 2002, and for each fiscal year thereafter, each PBRHC is entitled to the payment amount (on a per visit basis) to which the PBRHC was entitled to in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the PBRHC during that fiscal year. To determine reasonable cost an 80th percentile cost ceiling will be applied. The cost ceiling applied to the cost per encounter for PBRHCs reimbursement is derived as follows:

   The PBRHCs are listed in ascending order based on their respective computed cost per encounter.

   The number of PBRHCs is multiplied by 80% to determine the position of the PBRHC that represents the 80th percentile. If the 80th percentile does not fall on a whole number, the Agency will round up or down to the nearest whole number. If the number falls on .0 to .49, we will round down. If the number falls on .50 or higher, we will round up. Thus, 80% of the PBRHCs will have computed costs per encounter that are equal to or less than those of the 80th percentile PBRHC. Likewise, the remaining PBRHCs will have computed costs per encounter in excess of the costs of the 80th percentile.

3. Reimbursement for an enrolled out-of-state PBRHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state PBRHC or the average encounter rate established by Alabama Medicaid for in-state facilities

4. A new PBRHC provider or a provider who constructs, leases, or purchases a facility, or has a Medicaid approved change in the scope of services, can request reimbursement based on an operating budget, subject to the ceiling established under this rule. After the actual cost report is received and desk reviewed for the budget period, an actual encounter rate will be determined. In this event, the PBRHC may be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. This difference may be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference. After the initial year, payment shall be set using the MEI methods used for other PBRHCs. A PBRHC that has a change of ownership can retain the previous owner's encounter rate if desired.
5. Costs Reimbursed by Other Than the PBRHC Rate. Costs that are reimbursed by other Alabama Medicaid Agency programs will not also be reimbursed in the PBRHC Program. Examples of such reimbursements include, but are not limited to:

   Maternity Waiver - Primary Contractor (Note: Costs for Maternity Waiver sub-contractors are not an allowable cost and will be shown only in the non-reimbursable section of the cost report)

   Prescription Drugs by enrolled pharmacy providers

   In-patient and out-patient surgical service fee-for-service payments
6. Grants, Gifts, Private Donations or the Income from Such Items, and Income from Endowments. Unrestricted grants, gifts, private donations or the income from such items, and income from endowments will not be deducted from operating costs in computing reimbursable cost. Grants, gifts, private donations, or the income from such items, or endowment income designated by a donor for paying specific operating costs must be deducted from the particular operating cost or group of costs.

Author: Keith Boswell, Reimbursement/QA

Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Section 702, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

History; Emergency rule effective October 1, 1993. Amended January 12, 1994, March 15, 1994, and January 12, 1995. Amended: Emergency Rule filed and effective March 20, 2001. Amended: Filed March 20, 2001; effective June 15, 2001.

Rule No. 560-X-60-.05. Overhead Costs.

Overhead costs are those costs not directly related to patient care. Overhead costs are those costs related to the PBRHC's facility and administration and management of the PBRHC.

Examples of Overhead Costs include, but are not limited to:

Salaries and benefit costs of the administration staff (Owners' compensation will be limited to reasonable cost - i.e., that which would be paid to an unrelated employee performing the same function).

Accounting and Auditing

1. Routine Bookkeeping
2. Preparation of cost reports
3. Auditing and related statements

(c) Nominal meeting expenses for Board Members

(d) Legal costs related to patient care

(e) Data Processing

1. Owned
2. Rented
3. Outside purchased service

Housekeeping

Maintenance

Security

Supplies

Malpractice Insurance

General Insurance

Telephone

Utilities (power, gas, and water)

Rent

Maintenance and Repairs

Depreciation

Amortization

Mortgage Interest

Other Interest

Medical Records

Home Office Cost (if appropriate)

Management fees not exceeding the cost of the provider of the services and not excluded under another section of this Chapter

Other costs, if appropriate

3. Purchase Discounts and Allowances, and Refunds of Expenses. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense. Discounts, in general, are reductions granted for the settlement of debts. Allowances are deductions granted for damage, delay, shortage, imperfection or other cause, excluding discounts and returns. Refunds are amounts paid back or a credit allowed on account of an over-collection. Rebates represent refunds of a part of the cost of goods or services. A rebate is commonly based on the total amount purchased from a supplier and differs from a quantity discount in that it is based on the value of purchases, whereas quantity discounts are generally based on the quantity purchased.

   All discounts, allowances, and refunds of expenses are reductions in the cost of goods or service purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they were received.

   Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due.

   Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable cost is required.

   In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

   As with discounts, allowances and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party organizations paying on the basis of cost.

4. Advertising Costs. The allowability of advertising costs depends on whether they are reasonable, appropriate and helpful in developing, maintaining, and furnishing covered services to Medicaid beneficiaries. To be reimbursable, such costs must be common and accepted occurrences in the field of the clinic's activity.

   Advertising costs incurred in connection with the clinic's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. These costs will be limited to $100.00 per year for the clinic. Costs connected with fund-raising are not included in this category and are therefore nonallowable.

   Costs of advertising for the purpose of recruiting medical and paramedical personnel for the clinic's salaried staff are allowable. Costs incurred in advertising for administrative or clerical personnel are allowable if the personnel would be involved in patient care activities or the development and maintenance of the facility.

   Advertising costs incurred in connection with obtaining bids for construction or renovation of the clinic's facilities should be included in the capitalized cost of the asset.

Insurance Costs. The reasonable costs of insurance purchased from a commercial carrier and not from a limited purpose insurer are allowable if the type, extent, and cost of coverage are consistent with sound management practice. Where a clinic has purchased insurance without the customary deductible feature and, as a result, is charged a substantially higher premium, the amount of the insurance premium which exceeds the insurance premium with the customary deductible clause is not an allowable cost.

Generally, the following types of insurance are recognized:

(a) Property Damage and Destruction. This type of insurance covers losses due to the damage to, or destruction of, the facility's physical property. Coverage is available to insure against losses resulting from fire or lightning, windstorm, earthquake, sprinkler leakage, water damage, automobile damage, etc.

(b) Liability. This insurance includes professional liability (malpractice, error in rendering treatment, etc.), worker's compensation, automobile liability, and general liability.

(c) Theft Insurance. This generally includes fidelity bonds and burglary insurance.

Taxes. When a clinic is liable for the payment of certain taxes, such payments made in accordance with the levying enactment of the state and lower levels of government may be included in allowable costs. The program will pay its proportionate share of such allowable expenses.

Clinic's are expected to obtain exemption from taxation whenever they can legally do so. When such exemptions are available but the clinic neglects to take advantage of them, incurred expenses for such taxes will not be recognized as allowable costs under the program.

Tax expense should not include fines and penalties. In general, taxes which the clinic is required to pay are includable in allowable costs except for:

Federal income and excess profit taxes.

State or local income and excess profit taxes.

Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives.

Taxes on any property which is not used in the rendition of covered services.

Taxes which are allowable for inclusion in costs under the program generally are included in overhead costs of the clinic.

Membership Costs. Clinics customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary operating costs. Generally, costs of clinics memberships in professional, technical, and business related organizations are allowable for purposes of program reimbursement. Generally, social and fraternal organizations concern themselves with activities unrelated to their members' professional or business activities and are, therefore, not allowable.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.06. Personnel Costs.

1. Orientation and On-The-Job Training. The costs of orientation and on-the-job training are recognized as normal operating costs and are allowable. Ordinarily, such training would be imparted within the clinic setting. If, however, the training requires outside instructions, costs of such training are allowable, if reasonable.
2. Fringe Benefits. Fringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death.
3. The costs of fringe benefits must be reasonable and related to patient care. Medicaid recognizes the following fringe benefits:

   Facility contributions to certain deferred compensation plans, if the plan does not favor top management. Deferred compensation plans will be limited to 7 1/2% of allowable annual salaries.

   Facility contributions to certain pension plans, if the plan does not favor top management.

   Paid vacation or leave, paid holidays, paid sick leave, voting leave, court or jury duty leave, all of which generally are included in employee earnings.

   Cost of health and life insurance premiums paid or incurred by the facility if the benefits of the policy inure to the employee or his beneficiary, if the plan does not favor top management.

   Medicaid will not recognize employee stock ownership plans or stock bonus plans.

   Other items not enumerated above may represent fringe benefits. However, before any other item is treated as a fringe benefit, refer it to the Medicaid Agency for approval.
4. Sick Leave. The reasonable cost of sick leave taken by an employee of a clinic is recognized as a fringe benefit and included in allowable costs only when the facility makes payment for the sick leave. Payment in lieu of sick leave taken is not recognized by the program as payment for sick leave but is recognized as additional compensation. To be included in allowable costs, this payment in lieu of sick leave taken, along with other forms of compensation paid to an employee, must be reasonable.
5. Vacation Costs. A vacation benefit is a right granted by an employer to an employee (a) to be absent from his job for a stipulated period of time without loss of pay or (b) to be paid an additional salary in lieu of taking the vacation. Vacation costs must meet all of the following conditions to be included in allowable costs.

   These costs must be included in the cost reporting period in which they are earned by the employee and must be computed from actual payroll records as related to each employee.

Where the clinic's vacation policy is consistent among all employees, the vacation must be taken or, if the employee elects to be paid in lieu of taking a vacation, the payment must be made within the period consistent with the vacation policy established by the clinic. Where the policy is not consistent among all employees, the vacation must be taken or payment in lieu of vacation must be made within two years after the close of the cost reporting period in which the vacation is accrued. If payment is not made within the required period of time or in those instances where the vacation benefits, accrued and included in allowable costs, are forfeited by the employee for cause, the current year cost report must be adjusted.

Amounts allowed for vacation benefits must be reasonable in themselves and, together with other compensation, result in reasonable compensation for services rendered.

Employer payroll taxes applicable to vacation, such as FICA, must not be accrued, but treated as a cost in the period when the vacation costs are paid.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.07. Travel Expense.

1. Travel expense incurred by a facility to send employees (except physicians, which is covered below) to attend a required educational workshop within the state which increases the quality of medical care and/or the operating efficiency of the facility is an allowable cost. Workshops on medical techniques, health applications, data processing, clinic accounting and cost finding, and other administrative activities are examples of the types of workshops for which travel expense will be recognized. Travel expense incurred by a facility to send physician employees to attend educational workshops for licensure requirements is an allowable cost if the workshop is held within the state. Any physician educational costs above the licensure requirements is an unallowable cost. Travel that is necessary and that is directly related to the operation of the clinic claiming reimbursement for the expense will be an allowable cost for reimbursement purposes pursuant to the following specific provisions.

   Automobile

   1. Reimbursement will be based on a standard mileage rate and will be limited to mileage which is documented by log entries. Reimbursement to employees for the use of their personal vehicles will be limited to the lessor of the actual reimbursement to the employee or the standard mileage rate per section (1)(a)3 of this rule.

      All log entries must be made at the time of travel, and log entries will be subject to verification during audit. Failure to timely and accurately account for travel mileage will result in a disallowance of this cost.

   2. Commuting mileage between the commuter's residence and the PBRHC is not allowable mileage for reimbursement purposes. Non-patient care travel is also not allowable.

   3. The standard mileage rate is as follows: The IRS mileage rates in effect on January 1 of the calendar year in which the cost report is filed. These rates will be applied on a per provider basis regardless of the number or type of vehicles used.

   4. No reimbursement will be made or considered for unusual or impractical vehicles, which include but are not limited to aircraft, motorcycles, farm equipment and other vehicles not necessary to the efficient operation of the clinic.

Other Travel

Costs of travel to out-of-state conventions or association meetings will be limited to those reasonable costs incurred by a clinic for two trips during each fiscal year. If the clinic bears the expenses of two persons attending the same convention or association meeting, such attendance will be counted as two trips. Reimbursement will be considered only for bona fide employees of the clinic whose attendance will benefit the operation of the clinic. Expenses related to travel expenses of employee spouses will not be eligible for reimbursement unless the spouse is a bona fide employee of the facility and has a legitimate reason, related to patient care, for such attendance. Since only patient care related travel is allowable, evidence must be on file to verify that the travel was patient related. Such evidence may be: (a) seminar registration receipts, (b) continuing education certificates, or (c) similar documentation. If verification cannot be made, reimbursement will not be allowed. Out-of-state travel living expenses will be limited to cost up to $125.00 per day for the length of the functions attended. Per diem for the date of return will be limited to cost up to $50.00 because lodging is not required.

Travel expenses in or out-of-state will be limited to the ordinary and necessary costs of transportation, food, lodging, and required registration fees.

Whenever out-of-state travel could be accomplished at a lower cost by utilizing air travel, reimbursement will be limited to the costs which would have been incurred if such air travel had been utilized and the costs normally incident to such air travel (meals, lodging, etc.).

No travel expenses of a nonbusiness nature will be reimbursed.

Travel which requires an overnight stay must be documented by a travel voucher which includes the following:

i. Date

ii. Name of person

iii. Destination

iv. Business purpose

v. Actual cost of meals and lodging (lodging must be supported by invoices, meal receipts must indicate number of meals served for any meal in excess of $10.00).

vi. Air, rail and bus fares (supported by an invoice)

2. Travel associated with political activities or lobbying efforts is not allowable. This type of travel is not directly related to patient care.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.08. Property Costs.

General Principles Relating to Property Costs. Property Costs include, but are not limited to, depreciation, interest, lease and rental payments, insurance on buildings and contents, and property taxes. In addition to the limitations contained in this rule, all property costs will be subject to the "prudent buyer" concept with each case to be considered on its own merit. Also, depreciation, interest, rent, insurance, and taxes associated with space and equipment used for non-covered services or activities must be eliminated from allowable property costs.

Depreciation

(a) Depreciation is that amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period or operation. Depreciation must be determined by using the straight line method.

(b) The principles of reimbursement for facility costs provide that payment for services should include depreciation on all depreciable type assets that are used to provide covered services to beneficiaries. This includes assets that may have been fully (or partially) depreciated on the books for the facility but are in use at the time the facility enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on a revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity. An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be: (1) identifiable and recorded in the facility's accounting records; (b) based on the historical cost of the asset or fair market value at the time of donation or inheritance, in the case of donated or inherited assets; and (c) prorated over the estimated useful life of the asset using the straight line method of depreciation.

(c) Depreciable Assets. Assets that a facility has an economic interest in through ownership regardless of the manner in which they were acquired, are subject to depreciation. Generally, depreciation is allowable on the assets described below when required in the regular course of providing patient care. Assets which a facility is using under a regular lease arrangement would not be subject to depreciation by the facility.

(d) Buildings. Buildings include, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

(e) Building Equipment. Building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc. The general characteristics of this equipment are: (1) affixed to the building, and not subject to transfer; and (2) a fairly long life, but shorter than the life of the building to which affixed. Since the useful lives of such equipment are shorter than those of the buildings, the equipment may be separated from building cost and depreciated over this shorter useful life.

(f) Major Moveable Equipment. Major moveable equipment includes such items as accounting machines, beds, wheelchairs, desks, vehicles, X-ray machines, etc. The general characteristics of this equipment are: (1) a relatively fixed location in the building; (2) capable of being moved as distinguished from building equipment; (3) a unit cost sufficient to justify ledger control; (4) sufficient size and identity to make control feasible by means of identification tags; and (5) a minimum life of approximately three years.

(g) Minor Equipment. Minor equipment must be expensed as of the date of purchase. Minor equipment includes such items as waste baskets, syringes, catheters, mops, buckets, etc. The general characteristics of this equipment are: (1) in general, no fixed location and subject to use by various departments of the facility; (2) comparatively small in size and unit cost; (3) subject to inventory control; (4) fairly large quantity in use; and (5) generally, a useful life of approximately three years or less.

(h) Land (Non-depreciable). Land (non-depreciable) includes the land owned and used in facility operations. Included in the cost of land are the costs of such items as off-site

sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the facility, and other land expenditures of a non-depreciable nature.

(i) Land Improvements (Depreciable). Depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the facility).

(j) Lease Hold Improvements. Lease hold improvements include betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

(k) Accounting Records. The depreciation allowance, to be acceptable, must be adequately supported by the facility's accounting records. Appropriate recording of depreciation requires the identification of the depreciable assets in use, the assets' historical cost (or fair market value at the time of donation in case of donated assets), the method of depreciation, and the assets' accumulated depreciation.

(l) Useful Life of Depreciable Assets. The depreciable life of an asset is its expected useful life to the facility; not necessarily the inherent useful or physical life. The useful life is determined in light of the facilities experience and the general nature of the asset and other pertinent data. Some factors for consideration are: (1) normal wear and tear, (2) obsolescence due to normal economic and technological advances, (3) climatic and other local conditions, and (4) facility's policy for repairs and replacement. In projecting a useful life, facility's are to follow the useful life guidelines published by the American Hospital Association. The agency may allow lives different from these guidelines, if the provider requests consideration in writing. Requests must be addressed to Chief Auditor, Provider Audit, Medicaid Agency. However, the deviation must be based on convincing reasons supported by adequate documentation, generally describing the realization of some unexpected event. Factors such as an expected earlier sale, retirement or demolition of an asset may not enter into a determination of the expected useful life of an asset.

(m) Acquisitions. If a depreciable asset has at the time of its acquisition an estimated useful life of at least two (2) years and a historical cost of at least $300, or, if it is acquired in quantity and the cost of the quantity is at least $500, its cost must be capitalized, and written off ratably over the estimated useful life of the asset. If a depreciable asset has a historical cost of less than $300 or, if it is acquired in quantity and the cost of the quantity is less than $500 or if the asset has a useful life less than two (2) years, its cost is allowable in the year it is acquired. The facility may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the above criteria be exceeded.

(n) Determining Depreciation in Year of Acquisition and Disposal. The amount of depreciation recorded during the year of acquisition and year of disposal varies among clinics. The following methods are acceptable for computing first and last year depreciation amounts. Any other method for computing first and last year depreciation must be approved by the Medicaid Agency. Whatever method is adopted, it must be applied to all assets subsequently acquired.

1. Time Lag Alternatives. These result in delayed recording of depreciation after the actual date of acquisition. However, they provide the convenience of updating detailed, supportive accounting records at the end of certain time intervals.

   Up to Six Months Lag. Assets acquired during the first six months of the reporting year are subject to depreciation beginning with the first day of the seventh month of the reporting year. Assets acquired during the second six months of the reporting year are subject to depreciation beginning with the first day of the subsequent reporting year. Depreciation on disposal is based on the portion of the year in which the asset is disposed. If the asset is disposed of in the first half

of the reporting year, one-half year's depreciation is taken. If the asset is disposed of in the second half of the year, a full year's depreciation is taken.

Up to One Year Time Lag. Assets acquired during the reporting year become effective for depreciation on the first day of the subsequent reporting year. In the year of disposal a full year's depreciation is taken.

2. Half Year Depreciation. One-half year depreciation is taken in the year of acquisition regardless of acquisition date and one-half year depreciation is taken on disposition regardless of disposition date.
3. Actual Time Depreciation. Depreciation for the first reporting period is based on the length of time from the date of acquisition to the end of the reporting year. Depreciation on disposal is based on the length of time from the beginning of the reporting year in which the asset was disposed to the date of disposal.

(o) Disposal of Assets. Depreciable assets may be disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, fire or other casualty. In such cases, depreciation can no longer be taken on the asset, and gain or loss on the disposition must be computed. Where an asset has been retired from active service, but is being held for standby or emergency services, depreciation may continue to be taken on such assets. However, where asset has been permanently retired, or there is little or no likelihood that it can be effectively used in the future, no further depreciation can be taken on the asset. In such case, gain or loss on the retirement must be computed.

3. Interest

Necessary and reasonable interest expense on both current and capital indebtedness is an allowable cost. Interest is the cost incurred for the use of borrowed funds, generally paid at fixed intervals by the user. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term, usually for one (1) year or less. Current borrowing is usually for purposes such as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as the acquisition of facilities, equipment, and capital improvements. Generally, loans for capital purposes are long-term loans. Interest is usually expressed as a percentage of the principal. Sometimes, it is identified as a separate item of cost in a loan agreement. Interest may be included in "finance charges" imposed by some lending institutions or it may be a prepaid cost or "discount" in transactions with those lenders who collect the full interest charges when funds are borrowed. Reasonable finance charges and service charges together with interest on indebtedness are includable in allowable cost. To be allowable, interest must be: (1) supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required; (2) identifiable in the facilities accounting records; (3) related to the reporting period in which the costs are incurred; and (4) necessary and proper for the operation, maintenance, or acquisition of the clinic's facilities. To support the existence of a loan, the facility should have available a signed copy of the loan contract which should contain the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc. Where the lender does not customarily furnish a copy of the loan contract, correspondence from the lender stating the pertinent terms of the loan such as amount, rate of interest, method of payment, due date, etc., will be acceptable. Additional interest expense created by restatement of loan agreements, under generally accepted accounting principles, or created by imputing a different rate from the one stated in the loan agreement, will not be allowable. For example, an imputed interest expense resulting from the application of Accounting Principles Board Opinion No. 16 or No. 21, or any similar accounting principle, and any other imputed interest expense shall not be recognized as a valid interest cost for purposes of computing the provider's allowable Medicaid reimbursement. Various methods of identifying and accounting for interest costs are used. These include periodic cash payments of interest with or without repayment of all or part of the loan; prepayment of interest when the liability is incurred with charges to interest expense recorded in relation

to the accounting period; and accrual of interest with no cash payment with a corresponding record of the unpaid liability reflected in the accounting records. The method actually used depends on the type of loan and the terms of the loan agreement. Where interest expense has been determined to be allowable and the interest expense records are maintained physically away from the facility premises such as in a county treasurer's office, such records will be deemed to be those of the facility. This would be applicable where bond issues have been specifically designated for the construction or acquisition of the clinics facilities and the financial records relative to the bond issue are maintained by some governmental body other than the facility.

Necessary Interest. Necessary means that the interest be incurred on a loan made to satisfy a financial need of the facility and for a purpose reasonably related to patient care. For example, where funds are borrowed for purposes of investing in other than the facility's operations, interest expense is not allowable, such a loan is not considered "necessary." Likewise, when borrowed funds create excess working capital, interest expense on such borrowed funds is not an allowable cost. Necessary also requires that the interest be reduced by investment income. There is an exception to this general rule where the investment income is from grants and gifts, whether restricted or unrestricted, and which are not commingled with other funds. "Not commingled" means that the funds are kept physically apart in a separate bank account and not simply recorded separately in the facility's accounting records.

Proper Interest. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arms-length transaction in the money market when the loan was made. In addition, the interest must be paid to a lender not related to the facility through common ownership or control.

Mortgage Interest. A mortgage is a lien on assets given by a borrower to a lender as security for borrowed funds for which payment will be made over an extended period of time. Mortgage interest refers to the interest expense incurred by the borrower on a loan which is secured by a mortgage. Usually such loans are long-term loans for the acquisition of land, buildings, equipment, or other fixed assets. Mortgage loans are customarily liquidated by means of periodic payments, usually monthly, over the term of the mortgage. The periodic payments usually cover both interest and principal. That portion which is for the payment of interest for the period is allowable as a cost of the reporting period to which it is applicable. In addition to interest expense, other expenses are incurred in connection with mortgage transactions. These may include attorney's fees, recording costs, transfer taxes and service charges which include finder's fees and placement fees. These costs, to the extent that they are reasonable, should be amortized over the life of the mortgage in the same manner as bond expenses. The portion applicable to the reporting year is an allowable cost.

Interest During Period of Construction. Frequently, clinics may borrow funds to construct facilities or to enlarge existing facilities. Usually, construction of facilities will extend over a long period of time, during which interest costs on the loan are incurred. Interest costs incurred during the period of construction must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use for patient care. If the construction is an addition to an existing facility, interest incurred during the construction period on funds borrowed to construct the addition must be capitalized as a cost of the addition. After the construction period, interest on the loan is allowable as an operating cost.

Interest on Notes. A note is the contractual evidence given by a borrower to a lender that funds have been borrowed and which states the terms for repayment. Interest on notes is allowable as a cost in accordance with the terms of the note. Frequently, a note is issued as an instrument evidencing a loan which may have a term running several years. The interest on such a loan is incurred over the period of the loan. Under the accrual method of accounting, the interest cost incurred in each reporting period is an allowable cost in the applicable reporting period. If, under the terms of the loan, the interest is deducted

when the loan is made (discounted), the interest deducted should be recorded as prepaid interest. A proportionate part of the prepaid interest is allowable as cost in the periods over which the loan extends.

4. Sale and Lease back and Lease-Purchase Agreements.

Sale and Lease back Agreements - Rental Charges. Where a facility enters into a sale and lease back agreement with a non-related purchaser involving plant facilities or equipment, the incurred rental specified in the agreement is includable in allowable cost if the following conditions are met:

1. The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area; the type, expected life, condition and value of the facilities or equipment rented and other provisions of the rental agreements;
2. Adequate alternate facilities or equipment which would serve the purpose are not or were not available at lower cost; and
3. The leasing was based on economic and technical considerations.
4. If all these conditions were not met, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs had he retained legal title to the facilities or equipment, such as interest or mortgage, taxes, depreciation, insurance and maintenance costs.

Lease Purchase Agreement - Rental Charges.

Definition of Virtual Purchase. Some lease agreements are essentially the same as installment purchases of facilities or equipment. The existence of the following conditions will generally establish that a lease is a virtual purchase:

i. The rental charge exceeds rental charges of comparable facilities or equipment in the area;

ii. The term of the lease is less than the useful life of the facilities or equipment; and

iii. The clinic has the option to renew the lease at a significantly reduced rental, or the clinic has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time acquisition by the clinic is permitted.

Treatment of Rental Charges. If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased. If the asset is returned to the owner, instead of being purchased, the deferred charge may be expensed in the year the asset is returned. Where the term of the lease is extended for an additional period of time, at a reduced lease cost, and the option to purchase still exists, the deferred charge may be expensed to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership. On the other hand, if the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be expensed to the extent of increasing the reduced rental to a fair rental value.

Allowance for Depreciation on Facilities Leased for a Nominal Amount.

Some clinics might lease their facilities from municipalities at a nominal rental (usually for $1.00 per year) and the lease generally covers the useful life of the facility. Under most lease arrangements the tenant (lessee) maintains the property and pays the cost of any improvement or addition to the facility. When such improvement or addition is made the lessee may properly amortize its cost. The amortization allowance is includable in allowable cost. At the end of the lease, improvements and additions made by the lessee become the property of the lessor. However, in some instances the lease agreement provides that title to any additions or improvements is to revert to the owner in the first year they are used. In such cases, the cost of any addition or improvement would be similarly amortized and the amortization allowance would also be includable in allowable cost. It is the general practice of the clinic to include its charges (and cost) an amount to cover depreciation on the leased facilities as distinguished from capital improvements made by the lessee. In recognition of this practice, most third parties that reimburse clinics on the basis of cost allowed depreciation (but not interest) on facilities that have been leased for a nominal rental. In view of this and since this type lease arrangement in such cases generally contemplates the occupancy by the lessee for the period of the useful life of the facility, depreciation on the leased facility may be included in allowable cost under the conditions described below.

Analysis of Lease Arrangement. Each case must be decided on its own merit for depreciation to be allowed. The lease must contemplate that the lessee will make any necessary improvements and will properly maintain the facility. The lease may and frequently does cover the useful life of the asset; if not, however, as in the case of the year to year lease, such lease should be examined closely to determine whether the renewal and other provisions of the lease contemplate that the clinic will use the facility to the extent of its useful life. Where the intent and provisions of the year to year lease permit the clinic to have the benefit of the useful life of the facility, such lease should be treated, for depreciation purposes, in the same manner as a long-term lease that covers the useful life of the asset. The actions of the lessee and lessor in such cases should indicate that the intent of both parties is to continue the lease arrangements for the useful life of the asset. Of course, other facts should be considered together with the past actions of the lessee and lessor in order to determine whether or not the asset will and can be used by the lessee for the asset's full useful life. The lease should have no restrictions on the free use of the facility by the lessee. In addition, the lease should not provide for any indirect benefits to the lessor or to those connected with the lessor. For example, if the lease requires that the lessee furnish free clinic services to the employees of the lessor, then depreciation should not be allowed. In such cases, the cost of the services furnished to the lessor's employees would be appropriately included when determining allowable costs.

Equipment Rental. Reasonable costs of such rental equipment as is normally and traditionally rented by health care institutions and which is rented from a non-related organization, are allowable provided the arrangement does not constitute a lease-purchase agreement. All items leased under a lease-purchase agreement must be capitalized and depreciated over the useful life of the asset.

Insurance on Building and Contents. The reasonable costs of insurance on buildings and their contents used in rendition of covered services purchased from a commercial carrier and not from a limited purpose insurer (Ref. Provider Reimbursement Manual, Section 2162(2)) will be considered as allowable costs.

Property Taxes. Ad valorem and personal property taxes on property used in the rendition of covered services are allowable under this section. Fines, penalties or interest related to those taxes are not allowable.

Life and Rental Insurance. Premium payments for life insurance required by a lender or otherwise required pursuant to a financing arrangement will not be an allowable cost. Loss of rental insurance will also be considered an unallowable cost.

Donation of the use of space. A PBRHC may receive a donation of the use of space by another organization. In such case, the PBRHC may NOT impute a cost for the value of the use of space and include the imputed cost in allowable costs. The PBRHC can include in the allowable costs of the PBRHC, items such as costs of janitorial services, maintenance, repairs, etc., if used full time by the PBRHC for patient related care and paid for by the PBRHC.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.09. Costs to Related Parties.

1. Allowable costs incurred by a provider for services or goods provided by Related Parties will not exceed the net cost of the services or goods to that Related Party, and that cost cannot exceed the fair market value of the items or services involved.
2. Under no circumstances will rent paid to a Related Party be includable in allowable costs. In such cases, lessor's costs may be included in allowable costs provided that such costs do not exceed the fair market value of the leased assets.
3. The provisions of the Provider Reimbursement Manual shall be applicable in determining whether a Related Party relationship exists.

Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.10. Chain Operations.

A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care.

The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicaid program is that of a related organization to participating facilities. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services management direction and control, and other services. To the extent the home office furnishes services related to patient care to a facility, the reasonable costs of such services are includable in the facility's cost report and are reimbursable as part of the facility's costs. Where the home office of the chain provides no services related to patient care, no home office cost may be recognized in determining the allowable costs of the facilities in the chain.

Very often the home office of a chain organization charges the facility in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, and such fees must be deleted from the facility's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the facility.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.11. Unallowable Expenses.

General

All payments to providers for services rendered must be based on the reasonable cost of such services covered by the Alabama State Plan. It is the intent of the program that providers will be reimbursed the reasonable costs which must be incurred in providing quality patient care. Implicit in the intent that reasonable costs be paid are the expectations that the provider seeks to minimize costs and that costs do not exceed what a prudent and cost-conscious buyer pays for a given item of service or product. If costs are determined to exceed the level that prudent buyers incur in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not allowable.

Costs related to patient care include necessary and proper costs involved in developing and maintaining the efficient operation of patient care facilities. Necessary and proper costs related to patient care are those which are usual and accepted expenses of similar providers.

Overhead costs which will not be allowed are listed below. This listing is not intended to be all inclusive. Other overhead costs which violate the prudent buyer concept or are not related to patient care will not be reimbursed by the Alabama Medicaid Agency.

(a) Management Fees. Management firms, individuals and consultants which duplicate services already provided, or in a clinic in which a full-time administrator is employed. Excluded from this rule are those management contracts required incident to a bond issue for a valid business purpose.

(b) Director's Fees

(c) Compensation to owners and other personnel not performing necessary functions

(d) Salaries which are paid to personnel performing overlapping or duplicate functions

(e) Legal Fees and Expenses

Retainers

Relating to informal conferences and fair hearings

Relating to issuance and sale of capital stock and other securities

Relating to creation of corporations or partnerships

Relating to business reorganization

Services for benefits of stockholders

Acquisition of clinics or other business enterprises

Relating to sale of clinics and other enterprises

In connection with criminal actions resulting in a finding of guilt or equivalent action or plea

Other legal services not related to patient care

(f) Outside Accounting and Audit Fees and Expenses

Personal tax returns

Retainers

Relating to informal conferences and fair hearings

Relating to issuance and sale of capital stock and other securities

Relating to creation of corporations or partnerships

Relating to business reorganization

Services for the benefits of stockholders

Acquisition for clinics or other business enterprises

Relating to sale of clinics and other enterprises

In connection with participation in criminal actions resulting in guilt or equivalent action or plea

Other accounting services not related to patient care

(g) Taxes

1. Personal income
2. Property not related to patient care
3. Corporate income tax
4. Vehicle tag & tax

(h) Dues

Club

Civic

Social

Professional organization dues for individuals

Non-patient care related organization

(i) Insurance

1. Life
2. Personal property not used in patient care
3. On real estate not used in providing patient care
4. Group life and health insurance premiums which favor owners of a clinic or are for personnel not bona fide employees of the clinic

(j) Special assessments from Health Care Association

(k) Bad debts and associated collection expenses

(l) Employees relocation expenses

(m) Penalties

Late Tax

Late payment charges. (None: If a clinic can fully document that a late payment charge is directly due to late Medicaid payments, the amount of the late payment charge will be an allowable cost.)

Bank overdraft

Fines

(n) Certain Real Estate Expenses

Appraisals obtained in connection with the sale or lease of a clinic (unless required by Medicaid)

Costs associated with real estate not related to patient care

(o) Interest Expense

1. Interest associated with real estate in excess of clinic needs or real estate not related to patient care.
2. Interest expenses applicable to penalties
3. Construction Interest (must be capitalized)
4. Interest paid to a related party
5. Interest on personal property not related to patient care
6. Interest on loans not associated with patient care

7. Imputed interest

(p) Licenses

Consultants

Professional personnel

(q) Donations and Contributions

(r) Accreditation Surveys

(s) Telephone Services

1. Mobile telephones, beepers, telephone call relays, automated dialing services
2. Long distance telephone calls of a personal nature

Any costs associated with corporate stock records maintenance

Any expenses associated with political activities or lobbying efforts are not allowable

3. Prior Period Costs and Accounts Payable

The Medicaid reimbursement rate is calculated to provide adequate funds to pay business expenses in a timely manner. Costs incurred in prior periods but not paid must be accrued and reported in that period during which the costs were incurred. Payment of prior period cost in the current year is not an allowable cost. Exceptions will be allowed, based on reasonableness, for small invoices which, in total, do not exceed $500.00 per fiscal period. These invoices must be as a result of no fault of the provider. Any pattern of abuse will cause the costs in question to be automatically disallowed by the Agency.

Short-term liabilities must be paid within ninety (90) days from the date of invoice; otherwise, the expense will not be allowed unless the provider can establish to the satisfaction of Medicaid that the payment was not made during the 90 days for a valid business reason.

Actual payment must be made by cash or negotiable instrument. For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and must be payable to order of or to bearer. All voided instruments, whether voided in fact or by devise, are considered void from inception.

A provider who files for and is awarded protection under Chapter 11 of the Federal Bankruptcy Code may be given consideration in a current year cost report for actual payment of prior period allowable costs which have been disallowed in prior period cost reports due to failure to make actual payment of the cost claimed. In order for payment of these prior year allowable costs to be considered under a current year cost report, they must have been paid pursuant to a court approved plan for reorganization under Chapter 11 of the Federal Bankruptcy Code. The allowable costs will not include any interest or penalty incurred for failure to make payment in prior year. The Agency will not reimburse interest expense generated from loans incurred to pay any such allowable prior period costs. Any such (untrended) allowable cost shall be added to the encounter rate after the normal rate setting process. It will be subject to the 80th percentile ceiling, thus the providers cost must be below the ceiling rate for any possible reimbursement of these prior period costs to occur.

4. Bad Debts. Bad debts resulting from beneficiaries' failure to pay are to be treated as noncovered costs. Hence, such bad debts cannot be included in allowable costs.

5. Research Costs

(a) Costs, incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

(b) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies and other private organizations, as well as individuals, sponsor or contribute to the support of medical and

related research. Funds available from such sources are generally ample to meet basic medical and clinic research needs

Luxury Items or Services

Where clinic operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Luxury items or services are those that are substantially in excess of or more expensive than the usual items or services rendered within a clinic's operation to the majority of patients.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.12. Accounting Records.

1. The provider must submit adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be presented on the accrual basis of accounting. This basis requires that revenue must be allocated to the accounting period in which it is earned and expenses must be charged to the period in which they are incurred, regardless of when cash is received or disbursed.
2. Cost and statistical information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for supplies, services, or assets. This includes all ledgers, books, records, and original evidence of costs which pertain to the costs reported. Financial and statistical records should be maintained in a consistent manner from one period to another; however, the regard for consistency should not preclude a desirable change in accounting procedures provided that full disclosure of significant changes is made.
3. The following records and documentation must be kept by the provider and must be available for audit inspection by Medicaid:

   General Ledger

   Disbursements Journal

   Cash Receipts Journal

   Payroll Journal

   Working Trial Balance and Adjusting Entries

   Patient Records

   Purchases Journal

   Time Sheets
4. All information contained in the provider's General Ledger must be capable of audit verification. Disbursements must be supported by invoices which detail the quantity and price of goods and services purchased, together with evidence that such goods and/or services were received. Disbursements made without proper documentation will not be allowable for Medicaid reimbursement purposes. This documentation should be filed in chronological order, either alphabetically or in some other reasonable manner capable of being audited. Payroll journals must be supported by time cards or other documentation, such as time sheets, signed by the employee and verified by his/her department head. (Time sheets for physicians can be signed for the physician by the clinic manager.) Each time card or other documentation must also indicate the hours worked by the employee, the rate of pay for the services rendered by the employee, and must be identified by the cost clinic, to which the expense should be charged.
5. Subsidiary records which must be kept by the provider and be readily available for audit and inspection include, but are not limited to:

   Accounts Receivable ledger sheets or cards which agree with the General Ledger control account (to include fiscal year end aging schedules)

   Accounts Payable Ledger sheets or cards which agree with the General Ledger control account (to include fiscal year end aging schedules)

Notes Receivable

Notes Payable

Long-Term Debt evidenced by amortization schedules and copies of the original debt transaction

Insurance policies together with invoices covering the fiscal year reported

Depreciation Schedules showing the cost of the facility and equipment

Payroll Tax Returns

Income Tax Returns

Bank Statements, cancelled checks, deposit slips, voided checks, and bank reconciliations

A signed copy of the current lease

Automobile travel logs

6. Petty Cash Funds shall be maintained under the Imprest System. The disbursement of these funds shall be substantiated by an invoice and/or voucher detailing the date of disbursement, expense category, and name of person disbursing the funds.
7. All documents, work papers, and schedules prepared by or on behalf of the provider which substantiate data in the cost reports must be made available to Medicaid auditors and investigators upon request.
8. The provider will provide adequate desk space and privacy to Medicaid auditors and investigators during the progress of audits. The provider's personnel or personnel representing an outside independent accountant may be present at a Medicaid audit and be allowed access to the Medicaid auditors and workpapers only at the invitation and discretion of the Medicaid auditors during the course of their work at the provider's establishment.
9. In the event a Medicaid auditor or investigator is denied access to a provider's records, the provider will be advised of the contract provisions governing inspection and review of these records by authorized representatives. The provider will be advised that if access to records is not granted, the provider will be given ten (10) calendar days in which to furnish the records to Medicaid at its Montgomery offices. If a provider fails to comply within the ten (10) day period, Medicaid will reduce all subsequent reimbursement payments by the costs it has been unable to substantiate.
10. If the provider fails to keep the minimum financial records required to properly substantiate reported costs, the provider will be subject to termination from the Medicaid program.
11. All books and records required to be kept and made available to Medicaid personnel by a provider will be made available at the facility unless this requirement is specifically waived in writing, in advance by the Chief Auditor, Provider Audit, Medicaid.
12. If a provider who has been given three (3) full working days notice of an audit fails to make the required records, including any not maintained at the facility, available at that facility, the Medicaid auditor(s) will return to the Medicaid Agency, and the provider will be given ten (10) calendar days to present all of the accounting records at the Medicaid office. Should the provider fail to present all of the accounting records at the Medicaid office during the allotted time period, Medicaid will consider all payments made to the provider during the time period covered by the records sought to be audited to be overpayments and may proceed to recover those overpayments from the provider.
13. If Medicaid is required to go out of state for an audit, the organization being audited will bear all expenses and costs related to the audit, including, but not limited to, travel and reasonable living expenses, and those costs will not be allowable on any subsequent cost report.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.13. Cost Reports.

General - Cost report filing, using Medicaid prescribed cost report forms, is mandatory for all PBRHCs. Each PBRHC will have its own provider number and file its own cost report. This means that if a provider has five clinics, each with its own Medicare number, that will be five provider numbers and five cost reports.

Cost Report Year-Ends - Each PBRHC is required to file a complete cost report for each fiscal year. The PBRHC fiscal year-end must be the same as the affiliated provider; i.e., hospital, nursing facility, home health agency, etc. This is because you must show the allocation of costs to the PBRHC through a step-down procedure. If an affiliated provider has five clinics, costs must be step-down separately to the five individual clinics. If a clinic is a part of a hospital, the hospital cannot file an abbreviated hospital cost report. The hospital cost report must contain all schedules and attachments. The PBRHC cost report is due ninety (90) days after the fiscal year end.

Cost Report Filing - Two copies of the cost report must be received by Medicaid three months after the cost report year-end. Each copy will have an original signature of the administrator or an officer of the PBRHC. The signature must be preceded by the following certification: I HEREBY CERTIFY that I have examined the accompanying worksheets prepared by _____ for the reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief it is a true, correct and complete statement prepared from the books and records of the PBRHC in accordance with applicable instructions, except as noted.

_____

Signature (Officer or Administrator) Title Date

Any cost report received by Medicaid without the required original signature and/or without the required certification will be deemed incomplete and returned to the provider.

4. Extensions. Cost reports shall be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by the PBRHC. Extensions may be granted only upon written approval by Medicaid for good cause shown. An extension request must be in writing, contain the reasons for the extension, and must be made prior to the cost report due date. Only one extension, for a maximum of thirty (30) days, per cost reporting year will be granted by the Agency.
5. Penalties. If a complete cost report is not filed by the due date, or an extension is not requested or granted, the provider shall be charged a penalty of one hundred dollars ($100.00) per day for each calendar day after the due date; this penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting documentation. Once a cost report is late, Medicaid shall suspend payments to the provider until the cost report is received. A cost report that is over ninety (90) days late may result in suspension of the provider from the Medicaid program. Further, the entire amount paid to the provider during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The provider will have thirty (30) days to either refund the overpayment or file the delinquent cost report after which time Medicaid may institute a suit or other action to collect this overpayment amount or the delinquent cost report.
6. Cost reports will be deemed immutable with respect to the reimbursement for which the provider is entitled for the next succeeding fiscal year, one year from the date of its receipt by Medicaid, or its due date, whichever is later. Providers will have this one year period within which to resubmit their cost reports for the purpose of correcting any material errors or omissions of fact. This one year limitation does not apply to adjustments in cost reports that are initiated by Medicaid. Medicaid retains the right to make adjustments in cost reports at any time a material error or omission of fact is discovered.
7. Providers who terminate their participation in the Medicaid program, by whatever means, must provide a written notice to the Agency thirty (30) days in advance of such action. Failure to provide this written notice shall result in a one hundred dollar ($100.00) per day penalty being assessed for each day short of the 30 day advance notice period (up to a maximum of $3,000.00). Terminating providers must file a final cost report within seventy-five (75) days of terminating their participation in the program. Final payment will not be made by the Medicaid Agency until this report is received. Failure to file this final cost report will result in Medicaid deeming all payments covered by the cost

report period as overpayments until the report is received. Additionally, a penalty of one hundred dollars ($100.00) will be assessed for each calendar day that the cost report is late.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.14. Audit Adjustment Procedures.

Audit adjustments will be paid or collected by a combination of (1) changing the rate of the facility and (2) a lump sum settlement for the amount under/over paid for the period prior to the effective date of the rate change.

Under/Overpayment situations arising from the audit of a terminating cost report will be paid or recouped by a lump sum settlement.

All adjustments will be subject to the limitations set out in this Chapter and subject to the appropriate ceilings.

Collection procedures will be applied only after the facility has been given thirty (30) days in which to disagree with any of the disallowances contained in the report of audit.

A copy of the report of audit will be forwarded to the Reimbursement and Rate Analysis Section when the report of audit is mailed to the facility. After the thirty (30) day notification period is up and no request for an informal conference has been received, a new rate will be calculated based on audit adjustments in the report of audit. The new rate will be effective for billing purposes on the 1st day of the following month. A final audit computation sheet will be prepared. The audit settlement will be collected or paid in a lump sum amount. This lump sum amount for the months prior to the effective date of the rate change is computed by applying the adjustment of the rate to the total Medicaid days in the overpayment/underpayment period.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.15. Appeals.

1. Facility administrators who disagree with the findings of the Medicaid desk audits or field audits may request, in writing, an informal conference at which they may present their positions. Such written requests must be received by the Provider Audit Section at Medicaid within thirty (30) days of the date on which Medicaid mails the audit report, or new rate, as the case may be, to the provider.
2. Administrators who believe that the results of the informal conference are adverse to their facility may ask, in writing, for a Fair Hearing, which will be conducted in accordance with Medicaid Regulations. Such written requests must be received by the Legal Counsel at the Medicaid Agency within fifteen (15) days of the date on which Medicaid mails to the provider its determination on the issues presented at the informal conference.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.16. Negligence and Fraud Penalties.

1. Whenever an overpayment of Medicaid reimbursement received by a provider from Medicaid results from the negligent or intentional disregard of Medicaid Reimbursement Principles by the provider or its representatives (but without intent to defraud), there will be deducted from any reimbursement thereafter due the provider a penalty equal to 5% of such overpayment.
2. If any part of such an overpayment by Medicaid to the provider is due to fraud on the part of the provider or any of its representatives, there will be deducted from any subsequent reimbursement due the provider on proof of fraud, a penalty equal to 50% of the overpayment.
3. The penalties imposed under Rules No. 560-X-60-.16(1) and (2) of this Code shall be in addition to and shall in no way affect Medicaid's right to also recover the entire amount of the overpayment caused by the provider's or its representative's negligence or intentional disregard of the Medicaid Reimbursement Principles or fraud.
4. Whenever the cost of a good or service has been previously disallowed as the result of a desk audit of a provider's cost report and/or a field audit by Medicaid and such cost has not been reinstated by voluntary action of Medicaid as the result of an administrative hearing, or by a court order, such costs shall not thereafter be included as an allowable cost on a Medicaid cost report. The inclusion by the provider or its representative of such a cost on a subsequent cost report, unless the provider is actively pursuing an administrative or judicial review of such disallowance, will be considered as negligent and/or intentional disregard of the Medicaid Reimbursement Principles and subject to the 5% penalty imposed by Rule No. 560-X-60-.16(1) of this Code based upon the amount of overpayment which has or which would have resulted from the inclusion of such cost had its inclusion not been detected. Such inclusion shall also be subject to the provisions of Rule No. 560-X-60-.17 relating to intentional or negligent disregard of the Medicaid Reimbursement Principles.
5. For purposes of the preceding paragraph, a provider shall be considered as having included a previously disallowed cost on a subsequent year's cost report if the cost included is attributable to the same type good or service under substantially the same circumstances as that which resulted in the previous disallowance. Examples of such prohibited inclusions include, but are not limited to:

   Inclusion of the portion of rental payment previously disallowed as being between related parties.

   Inclusion of an amount of compensation which has previously been disallowed as unreasonable during a prior period.

   Inclusion of a cost not related to patient care which has previously been disallowed.

   Improper classification or allocation of costs to cost clinics.
6. Rule No. 560-X-60-.16(4) shall NOT be interpreted as indicating that a provider's or his representative's initial entry of a cost item on a cost report will not be treated as a negligent or intentional disregard of the Medicaid Reimbursement Principles.
7. Any provider who knowingly files or allows to be filed a cost report which has been prepared by a person who has been suspended as a Cost Report Preparer during his period of suspension, shall be subject to termination of its contract, and, in addition, subsequent reimbursement otherwise due the provider shall be reduced by $3,000.00, as though the cost report had not been received by Medicaid during the first thirty (30) day period following the due date for filing such report. (See Rule 560-x-60-.13.)
8. Providers and their representatives who are uncertain as to whether the inclusion of a cost in a cost report is in violation of the Medicaid Reimbursement Principles should footnote or otherwise call attention to the entry in question and specifically disclose the dollar amount and the portion of the cost report entry as to which they are in doubt.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

Rule No. 560-X-60-.17. Cost Report Preparers.

Cost Report Preparers. "Cost Report Preparer" includes any person (including a partnership or corporation) who, in return for compensation, prepares or employs another to prepare all or a substantial portion of a Medicaid cost report. A Cost Report Preparer can include both the actual preparer of the report as well as his or her employer. Where more than one person aids in filling out a Medicaid cost report, the one who has primary responsibility for the preparation of the report will usually be a preparer, while those involved only with individual portions of the report will usually not be preparers. Any person who supplies enough information and advice so that the actual completion of the return is a mere mechanical or clerical matter is a Cost Report Preparer even though the person doesn't actually place or review the placement of the information on the cost report.

Refusal of Cost Reports. Medicaid will refuse to accept cost reports prepared by a Cost Report Preparer who:

Has shown a pattern of negligent disregard of the principles established by or incorporated by reference into this Code;

Prepares a cost report evidencing an intentional disregard of the Medicaid Reimbursement Principles;

Has given false or misleading information, or participated in giving false or misleading information to any Medicaid employee, the Alabama Medicaid Agency, or to any hearing officer authorized to conduct hearings with regard to Medicaid reimbursement issues, knowing such information to be false or misleading. "Information" includes facts or other information contained in testimony, Medicaid Cost Reports, financial statements, affidavits, declarations, or any other documents or statements, written or oral.

Medicaid will treat any cost report prepared by a Cost Report Preparer who has been determined to be ineligible to prepare Medicaid cost reports as incomplete and shall promptly return such Cost Report to the provider on whose behalf the report has been prepared. The receipt by Medicaid of such cost reports shall not satisfy, suspend, or stay the requirements of this Chapter relating to the timely filing of Medicaid Cost Reports.

3. Determination of Eligibility.

Upon receipt by any Medicaid employee of information indicating that a Cost Report Preparer may have engaged in conduct which could result in the refusal by Medicaid to accept cost reports prepared by such preparer under Rule No. 560-X-60-.19(2) of this Section, such information shall be promptly reported to Medicaid's Chief Auditor, Provider Audit who shall insure that an informal inquiry is made regarding the reliability of such information. Medicaid legal counsel and/or appropriate representatives of the Attorney General's office shall be consulted, as deemed appropriate.

Informal Inquiry.

1. If the Medicaid Chief Auditor, Provider Audit, based upon such informal inquiry, determines that there is substantial evidence that the preparer has engaged in conduct specified in Rule No. 560-X-60-.16, he will give written notice to the preparer which will offer the preparer the opportunity to refute such information or allegations. If the preparer fails to provide the Chief Auditor, Provider Audit with information which results in a determination by the Chief Auditor that the evidence of misconduct is insufficient to justify suspension, the Chief Auditor will, at the preparer's request, have a hearing arranged and will have the preparer notified that such an administrative hearing will be held with regard to the alleged misconduct.
2. Should the preparer fail to deny or provide documentation or information to refute the allegations made against him within thirty (30) days after the date of the mailing of the initial letter to the preparer, such allegations will be deemed to be admitted, and the preparer will have waived his right of hearing. The Chief Auditor, Provider Audit will then notify the preparer of his suspension under this rule.

3. The above described hearing will be set for a time no earlier than thirty (30) days after the date of the mailing of the initial letter to the preparer.

Procedures Related to Informal Inquiry.

1. Notice. The initial notice from the Chief Auditor, Provider Audit to the preparer will describe with sufficient specificity the allegations being made against him to allow him to respond to those allegations in a specific manner.
2. The Notice of Hearing. The notice of hearing to the preparer will repeat the allegations which constitute the basis for the proceedings and state the date, time, and place of the hearing. The hearing, as noted in Rule No. 560-X-60-.17(3)(b)1 above will be arranged only at the request of the preparer. Such notice shall be considered sufficient if it fairly informs the preparer of the allegations against him so that he is able to prepare his defense. Such notice may be mailed to the preparer by first class or certified mail, addressed to him at his last address known to the Chief Auditor, Provider Audit. A response or correspondence from the preparer or his representative shall be mailed to Chief Auditor, Provider Audit, Alabama Medicaid Agency at the Agency's current address.
3. Answer. No written answer to the notice of hearing shall be required of the preparer.
4. Hearing. The hearing shall be conducted in accordance with Medicaid's Regulations related to Fair Hearings. (Chapter 3 of the Alabama Medicaid Administrative Code.)
5. Failure to Appear. If the preparer fails to appear at the hearing after notice of the hearing has been sent to him, he shall have waived the right to a hearing and the Commissioner of Medicaid may make his or her determination without further proceedings.
6. Determination of Ineligibility. The determination of the ineligibility of a Cost Report Preparer to prepare Medicaid cost reports will lie solely with the Commissioner of Medicaid. The Commissioner will make such determination after giving due consideration to the written recommendation of the Hearing Officer, unless the preparer has waived his right to hearing, in which event there need be no recommendation by the Hearing Officer.
7. Notification of Ineligibility. If the determination of the Commissioner is that the preparer shall no longer be eligible to prepare Medicaid cost reports, the preparer shall be notified in writing, and the preparer shall thereafter not be eligible to prepare such reports unless and until authorized by the Commissioner of Medicaid to do so. Such preparer shall IN NO EVENT be eligible to prepare such cost reports during the two (2) year period immediately following his suspension. Any person who acts as a Cost Report Preparer during his period of suspension shall not thereafter be eligible to act as a Cost Report Preparer for a period of ten (10) years from the date of his original suspension. Any provider who knowingly allows a cost report to be prepared by a person who has been suspended under this Section will be subject to having its provider agreement cancelled and will be subject to the applicable penalties of Rule No. 560-X-60-.16 of this code.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Sections 405.2460 - .2472 and 447.371. Emergency rule effective October 1, 1993. This amendment effective January 12, 1994.

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Chapter 61. Children's Specialty Clinic Services

Rule No. 560-X-61-.01. General.

Children's Specialty Clinic Services are specialty-oriented services that are provided by an interdisciplinary team to children who are eligible for EPSDT services and are experiencing developmental problems. Children's Specialty Clinic Services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided in a clinic setting that is not part of a hospital, but is organized and operated to provide medical care to patients according to recognized standards of care for children with special health care needs.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 440.90. Rule effective May 13, 1996.

Rule No. 560-X-61-.02. Provider Participation.

(1) Eligible persons may receive Children's Specialty Clinic Services through providers who are under contractual agreement with Medicaid to provide services to children eligible for EPSDT services.

(2) Providers under this section are clinics that are organized apart from any hospital and operate to provide an integrated multidisciplinary medical/rehabilitation program designed to upgrade the physical functioning of handicapped disabled individuals by bringing specialized staff together to perform as a team.

(a) Clinics must meet recognized standards of care for children with special health care needs and employ on staff the following practitioners:

1. Specialty physicians
2. Nurses
3. Social workers/service coordinators
4. Physical therapists
5. Audiologists
6. Nutritionists
7. Speech/language pathologists

(b) Staff must be employed in sufficient numbers to meet the needs of the volume of children served.

(c) Staff must meet the minimum qualifications of 42 CFR 485.705 incorporated herein by reference.

(d) All practitioners serving children must meet state and federal criteria for participation in the Medicaid program.

(3) All Children's Specialty Clinic Services must be furnished by or under the direction of a physician. The physician must see the patient, prescribe care, and regularly review the prescribed program for continued appropriateness.

(4) Clinics must develop a patient care plan that provides medical and rehabilitative services to children with special health care needs as well as coordination and support services.

(5) Clinics must meet the following requirements for participation in the Medicaid program:

(a) Be licensed in the State of Alabama;
(b) Be independent of any hospital or physician’s office;
(c) Submit to routine audits by Medicaid;
(d) Complete an application with all required attachments;
(e) Sign a provider agreement;

(f) Sign a Direct Deposit Authorization;
(g) Sign a Civil Rights Statement of Compliance;
(h) Comply with the standards set out in (2) above.

(6) Governmental providers must furnish documentation regarding the source of public funds, statutory authority of regulatory agency, and be subject to the rulemaking process of the applicable Administrative Code.

Author: Debbie Flournoy, Program Manager, Medical Support
Statutory Authority: Title XIX, Social Security Act; State Plan; 42 CFR Section 440.90, 485.705.
History: Rule effective May 13, 1996. **Amended:** Filed April 20, 1999; effective July 13, 1999.
Amended: Filed June 20, 2006; effective September 15, 2006.

Rule No. 560-X-61-.03. Recipient Eligibility.

(1) All persons under twenty-one (21) years of age who have been certified as being eligible for Medicaid, who are eligible for EPSDT services, and are experiencing developmental problems are eligible for Children's Specialty Clinic Services.

(2) Alabama Medicaid Agency Administrative Code, Chapter One, General, contains information about the identification of Medicaid recipients.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 440.90. Rule effective May 13, 1996.

Rule No. 560-X-61-.04. Covered Services.

(1) Children's Specialty Clinic Services do not include services that have been rendered under other Medicaid programs.

(2) Children's Specialty Clinic Services are covered when provided by a Medicaid enrolled children's specialty clinic provider.

(3) Covered children's specialty clinic services include preventive, diagnostic, therapeutic, rehabilitative, and/or palliative items or services provided by a Medicaid approved provider who meets the requirements described in Section 560-X-61-.02. Specific types of services provided in Children's Specialty Clinics include: diagnosis of medical conditions, multidisciplinary evaluations, completion of durable medical equipment assessments, therapy services, nutrition services, case management services, orthotic and prosthetic services, vision and hearing services, and dental services for children experiencing developmental problems. For details of dental services covered in childrens specialty clinics see Rule No. 560-X-15-.06 (3) of the State of Alabama Administrative Code.

(4) A patient care plan is required for each child and a service coordinator is responsible for arranging specialty and needed social services for the family.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 440.90. Rule effective May 13, 1996. Effective date of this amendment July 10, 1998.

Rule No. 560-X-61-.05. Reimbursement.

(1) Children's Specialty Clinics will be reimbursed as follows:

(a) Governmental providers will be reimbursed by an encounter rate based on reasonable allowable costs, as defined by OMB Circular A-87, and established by the Medicaid Agency based on completion of the required cost report documentation.

(b) Nongovernmental providers will be reimbursed by a rate established by Medicaid based on usual, customary, and reasonable charges.

(2) Only one clinic visit per date of service per recipient will be reimbursed. Exception: A dental encounter may be billed in conjunction with a clinic visit for the same date of service for the same recipient.

Author: Lynn Sharp, Associate Director, Policy Development, Medical Services Division
Statutory Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 440.90.
History: Rule effective May 13, 1996, March 14, 1997, and July 10, 1998. Amended: Filed; April 20, 1999; effective July 13, 1999.

Rule No. 560-X-61-.06. Copayment (Cost Sharing).

(1) Medicaid recipients shall not be required to pay and providers may not collect a copayment for any of these services. Refer to Rule No. 560-1-X-.25(3) for copay information.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 440.130. Rule effective May 13, 1996.

Rule No. 560-X-61-.07. Payment Acceptance.

(1) Eligible Medicaid recipients are not to be billed for covered services once the recipient has been accepted as a Medicaid patient.

(2) The provider is responsible for any follow-up with the fiscal agent or Medicaid on denied claims.

(3) The recipient is not responsible for any difference between billed charges and Medicaid allowed charges.

(4) The recipient may be billed for non-covered services.

(5) Children's Specialty Clinic Services shall be billed utilizing the standard HCFA-1500 claim format and locally assigned procedure codes. The appropriate ICD-9-CM diagnosis code shall be required.

(6) Claims submitted for which there is no documentation, or for charges in excess or in violation of the provider's contractual agreement, are subject to recoupment by the Agency, and to referral for investigation and possible prosecution for fraud.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R Section 447.15. Rule effective May 13, 1996.

Rule No. 560-X-61-.08. Confidentiality.

(1) The provider shall not disclose, except to duly authorized representatives of federal or state agencies, any information concerning an eligible recipient except upon written consent of the recipient, his attorney, or his/her guardian, or upon subpoena from a court of appropriate jurisdiction. See Rule 560-X-20-.05, Third Party, for additional requirements regarding release of information.

(2) The provider must safeguard clinical records against loss, destruction, and/or unauthorized use.

Authority: Title XIX, Social Security Act; State Plan; 42 C.F.R. Section 431.306. Rule effective May 13, 1996.

Rule No. 560-X-61-.09. Maintenance of Records.

(1) The provider shall make available to the Alabama Medicaid Agency at no charge all information regarding claims for services provided to eligible recipients. The provider shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. Complete and accurate fiscal records which fully disclose the extent and cost of services shall be maintained by the provider.

(2) The provider shall maintain documentation of Medicaid clients' signatures. These signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the clients' signatures and dates of service.

(3) All records shall be maintained for a period of at least three (3) years plus the current fiscal year. If audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three (3)-year period, the records shall be retained until resolution and finality thereof. Such records shall be kept in a form that will facilitate the establishment of a complete audit trail in the event such items are audited.

Authority: State Plan for Medical Assistance; Title XIX Social Security Act; 42 C.F.R. Sections 431.17 and 433.32. Rule effective May 13, 1996.